PROJECT HOPE

Increasing the Quality of Child Survival and Maternal Care Services in the Navoi Oblast of Uzbekistan

Cooperative Agreement No.: FAO-A-00-99-00026-00

Detailed Implementation Plan for Phase 2

Project Location: Navoi Oblast, Uzbekistan
Phase 2 Duration: September 30, 2003 to September 29, 2007

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ANNEXES

ACRONYMS

ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infection
AVSC	Association of Voluntary Contraception
BCC	Behavioral Change and Communication
BCCWG	Behavioral Change and Communication Working Group
BF	Breast Feeding
BL	Baseline Survey
CAR	Central Asian Republics
CDD	Control of Diarrheal Disease
CI	Confidence Interval
COMH	Central Oblast Maternity House
CRMH	Central Rayon Maternity House
COH	Central Oblast Hospital
CRH	Central Rayon Hospital
CS	Child Survival
CSHGP	Child Survival and Health Grant Program
CYP	Couple Years of Protection
DFID	UK Department for International Development
DHS	Demographic Health Survey
DIP	Detailed Implementation Plan
EPI	Expanded Program on Immunization
FAP	Feldsher midwife post
FGD	Focus Group Discussions
FP	Family Planning
FT	Field Team
FE	Final Evaluation
GDP	Gross Domestic Product
HFA	Health Facility Assessment
HIV	Human Immunodeficiency Virus
HIS	Health Information System
HG	Healthy Generation
IEC	Information, Education, Communication
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
IMS	Information Management System
IUD	Intrauterine Device
KPC	Knowledge, Practice, Coverage
LAM	Lactational Amenorrhea Method
LQAS	Lot Quality Assurance Sampling
MCH	Maternal Child Health
MCWG	Management and Logistics Working Group
MOH	Ministry of Health
M&E	Monitoring and Evaluation

MSG	Mother Support Group
MT	Mid Term Evaluation
NGO	Non-Governmental Organization
NIS	Newly Independent States
ORT	Oral Rehydration Therapy
OHD	Oblast Health Department
PHC	Primary Health Care
PEPC	Promoting Effective Perinatal Care
PTP	Peer to Peer Counseling
QA	Quality Assurance
QAIWG	Quality Assurance and Improvement Working Group
QI	Quality Improvement
RAP	Rapid Appraisal Procedures
RH	Reproductive Health
SC	Steering Committee
TEWG	Training and Education Working Group
QA/QI	Quality Assurance/Quality Improvement
RAW	Reproductive Age Women
STD	Sexually Transmitted Disease
SUB	Rural community hospital
SVA	Rural physician ambulatory
SVP	Rural physician post
SM	Safe Motherhood
WRA	Women of Reproductive Age
TOT	Training of Trainers

A. EXECUTIVE SUMMARY

Project HOPE is delighted to have the opportunity to implement Phase 2 of the USAID/CSHGP "Increasing the Quality of Child Survival and Maternal Care Services Project in the Navoi Oblast of Uzbekistan." This project clearly builds on the solid and rewarding history from the CS-15 Phase 1 of this Project (9/1999 to 9/2003) where Project HOPE worked with the Navoi Oblast Health Department to improve child survival, safe motherhood, and reproductive health services in two pilot rayons.

Program Location. This extension project will expand activities to two new rayons -- Konimeh and Nurata-- while continuing to improve systems of monitoring and quality supervision in the old rayons – Navoi and Kiziltepa. The pilot rayons are mostly rural, although main highways connect the rayons to the Oblast Capital, Navoi City. The two new rayons, however, are the two farthest rayons from Navoi City and are often unreachable by car in the winter months. See Maps of region in **Annex A**.

Problem Statement. Navoi Oblast continues to be an area of considerable need. Navoi oblast statistics (2001) provide a picture of poor health status of young children and women of reproductive age. The reported IMR in Navoi is 17/1,000 lives births, but the actual rate is probably at least three times higher, using standard international definitions. ARIs, diarrheal diseases, measles, anemia, and malnutrition account for 55% of under five deaths.

The Navoi Oblast has one of the highest maternal mortality rates in the country, 73/100,000 live births compared to a national ratio of 34/100,000 live births. Ninety-five percent of pregnant women are anemic (39% severely anemic) - a contributor to peri natal and maternal deaths. Primary causes of maternal mortality are pregnancy-induced hypertension/toxemia, hemorrhage, and infection[1].

A glimpse of the Navoi health facilities helps explain the poor health indicators of the population. Facilities lack supervision and continuing education to provide health staff with new or improved knowledge and skills. Stocking health care facilities with necessary equipment and drugs to provide preventative and curative services remains a challenge. The Soviet culture of client passivity remains intact and the population is generally not aware of their patient rights or their responsibilities in terms of preventive care. Without the old system of adequately funded, comprehensive outreach to support curative services, many preventable illnesses frequently fall through the cracks.

Targeted Beneficiaries. This project directly targets an estimated 36,716 children 0-5 years of age, 77,479 women of reproductive age (WRA) (15-49 years old), and 25,505 Adolescents (15-18 years of age) distributed in the four project rayons. Indirectly, the Project's work at the Oblast level will support an additional 35,949 children 0-5 years of age, 81,241WRA, and 28,335 adolescents ages 15-18.

Major Strategies, Program Goals, and Objectives. The Navoi project focuses on (a)

[1] Navoi Oblast Health Department, HD, 2001

reducing the mortality and morbidity in children under five and women of reproductive age and (b) increasing adolescents' knowledge about reproductive and sexual health. This will be done through partnership and capacity building of the MOH and community education. The Project will introduce and expand the use of standard case management protocols. At the community level, Project HOPE will work with Mahkalla leaders and local schools to raise awareness of preventive care and timely health care seeking. For Phase 2, the project will continue to develop innovative, effective, and efficient approaches that can serve as a "laboratory" for lessons learned to incorporate in Project HOPE's MCH/RH/CS projects in Uzbekistan and Kyrgyzstan.

Estimated Level Of Effort: IMCI: ARI/Pneumonia Control 10%, IMCI: Control of Diarrheal Diseases 10%, IMCI: Child Nutrition 10%, Breastfeeding Promotion 10%, Safe Motherhood/Newborn Care 30%, and Family Planning 30%.

Documentation of Strategy: Progress towards achieving project objectives will be monitored by the following means: data collected by KPC survey; MOH's health information system; Health Facility tools; Lot Quality Assessment Sampling methodology; Training pre-and-post tests; and Rapid Assessment Procedures. The current MOH Health Information Systems provides services statistics, while the project will obtain additional indicators of performance, client satisfaction, quality of care and population based indicators.

Local Partners: Sustainability is the key concern of the second phase of the project, which focuses on capacity building, training, and the development of appropriate systems for the MOH. All activities will be implemented through or jointly with the Navoi Oblast Health Department and the Navoi Oblast Administration, which includes Makhallah leaders and active community participation. A MCH Steering Committee created during the first phase of the project will play an even more active and effective role in Phase 2 of the project with the creation of 4 subdivided working groups comprised of key decision makers in the MOH, makhalla administrations, local and international NGOs, and community members.

Category of the Original CSHGP Application: Cost Extension
Budget: *Federal* $1,299,851; *Non-Federal* $434,958 (See **Annex B** for detailed budget)
Start and End Dates: September 30, 2003 to September 29, 2007

USAID Input: Comments made during the final evaluation process by Andreas Tamberg, Health Advisor of USAID/CAR/Tashkent, were incorporated into expansion project. In addition, Susan Youll, CSHGP/ USAID provided observations and recommendations for the extension project in her trip report in September 2003.

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B. CSHGP DATA FORM

Child Survival Grants Program Project Summary

DIP Submission: Jun-29-2004
HOPE Uzbekistan

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Project Information:

Project Description:	The cost extension project will include scaling up of activities throughout 4 rayons of Navoi oblast, add pilot activities in Reproductive Health, pregnancy and neo-natal health. During the past CSH project, Project HOPE has trained and built the technical capacities of MOH staff of target Rayons to implement and expand child survival and reproductive health interventions. The project HOPE team has evolved technically and new staff were added to carry out this follow-on project. Project HOPE will continue providing technical support to the Oblast and Rayon Health Departments by means of: (1) training Oblast/Rayons' staff key child survival and reproductive health interventions; (2) adapting, field-testing and expanding standard case management protocols; and (3) developing and field-tested training curricula. In addition, for the new project, (4) will develop a Makhalla-based strategy, by identifying Makhalla-level organized groups and leaders and training them in key health

	interventions, and (5) improve monitoring and evaluation at service and community levels. Interventions for this cost extension include breastfeeding/baby-friendly hospital initiative (10%); ARI 10%, CDD 10%, and child feeding 10% (integrated under the IMCI Initiative); FP/RH (30%); and SM/PEPC (30%).
Partners:	MOH; Project HOPE's bilateral "Healthy Family" Project; UNICEF; Zdrav Plus; WHO; UNICEF; local NGOS: National Red Crescent Society, "Tumaris", the "Healthy Generation Foundation", and "Women's Socail Adaptation Center"; and community members, particularly adolescents.
Project Location:	Navoi Oblast

Grant Funding Information:

USAID Funding:(US $)	$1,299,851	**PVO match:(US $)**	$434,958

Target Beneficiaries:

Type	Number
infants (0-11 months):	5,805
12-23 month old children:	5,921
24-59 month old children:	24,990
0-59 month old children:	36,716
Women 15-49:	176,544
Estimated Number of Births:	6,053

Beneficiary Residence:

Urban/Peri-Urban %	Rural %
5%	95%

General Strategies Planned:

Strengthen Decentralized Health System
Information System Technologies

M&E Assessment Strategies:

KPC Survey
Health Facility Assessment
Participatory Rapid Appraisal
Lot Quality Assurance Sampling
Community-based Monitoring Techniques

Behavior Change & Communication (BCC) Strategies:

Mass Media
Interpersonal Communication
Peer Communication
Support Groups

Capacity Building Targets Planned:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
US HQ (CS unit) Field Office HQ CS Project Team	PVOs (Int'l./US) Local NGO Networked Group	(None Selected)	National MOH Dist. Health System Health Facility Staff Other National Ministry	Health CBOs

Interventions:

** IMCI Integration
** HF Training
Nutrition 10 **%**
** IMCI Integration
** HF Training
*** Growth Monitoring
** HF Training
Acute Respiratory Infection 10 **%**
** IMCI Integration
** CHW Training
** HF Training
*** Pneum. Case Mngmnt.
*** Case Mngmnt. Counseling
*** Access to Providers Antibiotics
*** Recognition of ARI Danger Signs
Control of Diarrheal Diseases 10 **%**
** IMCI Integration
** CHW Training

** HF Training
*** Water/Sanitation
*** Hand Washing
*** ORS/Home Fluids
*** Feeding/Breastfeeding
*** Care Seeking
*** Case Mngmnt./Counseling
Maternal & Newborn Care 30 **%**
** IMCI Integration
** HF Training
*** Emerg. Obstet. Care
*** Recog. of Danger signs
*** Newborn Care
*** Post partum Care
*** Delay 1st preg Child Spacing
*** Integr. with Iron & Folate
*** Normal Delivery Care
*** Birth Plans
*** STI Treat. with Antenat. Visit
** HF Training
Breastfeeding 10 **%**
** HF Training
*** Support baby friendly hospital
** HF Training
Family Planning & Reproductive Health 30 **%**
** HF Training
*** Knowledge/Interest
*** Youth FP Promotion
*** FP/HIV integration

*** Maternal/Neonatal Integration
*** Community Involvment
*** Access to Methods

Indicator	Numerator	Denominator	Estimated Percentage	Confidence line
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	0	0	0.0	0.0
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	14	29	48.3	25.7
Percentage of children age 0-23 months whose births were attended by skilled health personnel	412	420	98.1	1.8
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	0	0	0.0	0.0
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	69	110	62.7	12.8
Percentage of infants age 6-9 months receiving breastmilk and complementary foods	18	91	19.8	11.6
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	93	185	50.3	10.2
Percentage of children age 12-23 months who received a measles vaccine	163	185	88.1	6.6
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	0	0	0.0	0.0
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	148	408	36.3	6.6

Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	5	22	22.7	24.8
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	204	420	48.6	6.8
Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	0	0	0.0	0.0

Comments

C. DESCRIPTION OF DIP PREPARATION PROCESS

Brief description of steps taken to prepare this DIP

The Final Evaluation (FE)
The DIP development process started with the final evaluation of Phase I. The evaluation considered the Project in its role as a field laboratory for testing new innovations in maternal and child health in terms of impacts and lessons learned in the two pilot rayons of Navoi Oblast, as well as influences on broader thinking, practice and policy in the country and the region. The Executive Summary of the Final Evaluation can be found in **Annex C.**

Through this process, the FE team laid out concrete recommendations for Phase II of the project that specifically related to efficiency, design, sustainability, and emphasis on monitoring and evaluation (M&E). Key recommendations, which were based on data from both the KPC and Health Facility studies and have been incorporated into the DIP, are summarized here:

Safe Motherhood (SM)
- Safe Motherhood should be prioritized in the extension project.
- The planned establishment of a Safe Motherhood Center in Navoi should provide a focal point for training, monitoring and Information, Education and Communication (IEC) outreach.

Integrated Management of Childhood Illness (IMCI)
- Quality and sustainability will depend on further attention to institutionalizing monitoring and supervision systems and ensuring a consistent drug supply.

Breastfeeding (BF)
- Standardize female breastfeeding volunteers training and make it more frequent, adding new topics and refreshing old ones. Provide reference materials.
- Contemplate expanding the support group activities to the primary health facilities.

Reproductive Health (RH)
- More information on household spending patterns on contraception, would inform the design of appropriate social marketing mechanisms for contraceptives.
- User pay drug schemes should include contraceptives.

Adolescent Reproductive and Sexual Health (ARSH)
- Use adolescents to collect data on adolescent knowledge, behaviors and preferences; establish an adolescent advisory committee.
- Peer networking would be an effective way to disseminate information.
- Good supervision is important to ensure correct information is being disseminated.

Monitoring and Evaluation
- For the Navoi project to continue to play the role of laboratory for innovative new

approaches in MCH, RH and related areas, information management will have to be significantly strengthened.

Training

- On certificates: provide trainees with a letter of thanks for attending Project courses. Award certification after at least 3 monitoring visits (including written tests) ascertains a pre-established level of mastery.
- On maintaining quality training: the role of the IMCI, RH and soon to be established SM Centers in Navoi should include monitoring, to enable identification of refresher training needs.

Quality

- Supervision systems that enable continuous reinforcement of Quality Assurance (QA) approaches are critical to ensure sustainable institutionalization.

Drug Supply

- Pilot community-based cum clinic-based revolving drug scheme approaches in the extension Project.

Community mobilization

- Develop an integrated community mobilization/IEC strategy with specific targets.
- Establish an inquiry framework to monitor and measure the relative and synergistic impacts of various approaches.

Communications and materials for behavior change

- Sustainability: looking to national impact, scale, and the inevitable question of covering the recurrent costs for reproducing IEC materials beyond the life of the Project, continued liaison with other Projects and the Ministry of Health (MOH) will be essential.
- Since mass media is a part of most people's lives, and an inexpensive way to disseminate information widely, the extension should prioritize investigation of print, television and radio to place key IEC messages. Creative, humorous approaches should be considered.

Impact on national policy and programming

- The DIP for Phase II should proactively anticipate the Project's strategic, national role as a laboratory by allocating human resources and designing M&E systems and dissemination mechanisms to promote specific, targeted issues.

The FE also served to help Project HOPE, their partners in the Oblast MOH and Administration, and other major stakeholders in the communities stimulate discussions for: (a) defining an overall vision and objectives for improvements in health in the region, and (b) determining the steps for achieving this vision. Final evaluation results were shared with the Maternal and Child Health (MCH) Steering Committee and Pilot community leaders, where members analyzed FE results discussed whether or not they were satisfied with the results and how to achieve a greater impact in reproductive,

maternal and child health in their communities. The two groups also discussed the roles and responsibilities of the Oblast government (MOH and Oblast Administration), Project HOPE, private enterprises and the communities in reaching a healthier population. (Please see **Annex D** for DIP Process Schedule and for a List of individuals who participated in DIP process.)

Baseline Survey

A Knowledge, Practice, and Coverage (KPC) population-based baseline survey was conducted for Phase 2 of the project, incorporating lessons learned from the final evaluation. The survey included collection and analysis of data of: (a) mothers with children less than 24 months of age, (b) women of reproductive age, and (c) adolescents. A baseline Health Facility Assessment (HFA) will be carried out in the new rayons of this project in the course of working with each of the facilities as capacity building interventions proceed. This report will be submitted in the First Annual Report.

After carrying out the KPC baseline study, Project HOPE's Navoi team, a headquarters representative and an external consultant engaged local partners and stakeholders in the analysis of information in three separate meetings in Navoi City. The first analysis meeting was held for the survey supervisors and interviewers, which included MOH field staff, health educators, and NGO counterparts. The second meeting was comprised of Oblast and Rayon MOH officers and program chiefs. The third meeting, which was by far the most dynamic of the three, was with community leaders from the four pilot rayons. Local partners and stakeholders were asked to interpret the baseline survey results, compare the results with their own sources and experience, and to provide recommendations for project implementation. (Their work and analysis is included in the discussion in the Baseline Report, see **Annex E.**)

Following the baseline survey results analysis meetings, Project HOPE staff and the external consultant worked for an entire week formulating program strategies, objectives and activities. During that week, the team selected training resources and information, education, and communication (IEC) materials from those already in existence that they would use in the project. They also determined those technical materials that would have to be developed and/or customized. After this initial work was carried out in Navoi, Project HOPE staff, at both the field and headquarters levels, and the external consultant continued working on developing the DIP development via electronic communication.

Finally directly following the baseline survey, selected Navoi team took a course on the Lot Quality Assurance Survey (LQAS) methodology, which will be the M&E basis for collecting information on quality of service delivery, community-based activities and performance indicators. The first onsite implementation of LQAS will be held in June 2004.

D. REVISIONS (from the original application)

The direct beneficiaries presented in the original proposal were revised in consultation

with the Project HOPE staff and Oblast MOH. The project will not focus on the entire Oblast directly, but on only four rayons, versus the entire nine rayons of the Navoi Oblast. The total amount of beneficiaries for the project has been reduced to 36,716 children under 5 years of age, 77,479 women of reproductive age, and 25,505 adolescents 15-18 years of age (changed from the originally proposed 66,173 children under five and 186,506 women of reproductive age, of whom approximately 18% are adolescents.) The main reason for reducing the beneficiary population was that the project wants to move away from direct support of training activities and build capacity within the Oblast MOH to carry out these activities throughout the entire Oblast. Project HOPE believes that its work to improve the MOH systems of monitoring, supervision, and MCH protocols will have a multiplying effect on all the rayons. The indirect beneficiaries to benefit from this project will be an additional 35,949 children 0-5 years of age, 81,241 WRA, and 28,335 adolescents ages 15-18. Project HOPE will document the project's influence on both the direct and indirect beneficiaries over the life of the project.

There have been some changes from the originally proposed budget as well, although there are minimal differences in the overall amount that will be spent of either federal or non-federal funds. The three main changes are as follows: A large decrease ($85,302) in the supplies line item to be more realistic, based on findings from a past history analysis of spending; an increase of $44,674 in the USAID-approved indirect rate increasing from 19.84% to 25.04%; and an increase of $17,777 in staff personnel and salaries in the field and in the Headquarters due to expanding staff in the field, increase in salaries, and increase in Headquarters input. Please see **Annex F** for a review of key personnel for the Navoi Project.

E. DETAILED IMPLEMENTATION PLAN

1. Summary of Baseline and Other Assessments

a. Baseline Survey

The field team carried out a comprehensive baseline study (See **Annex E** for the Baseline (BL) survey report) to augment the information from the end-of-project evaluation studies in the original two rayons (both KPC and Health Facility studies). A 30-Cluster KPC study was carried out prior to DIP preparation. Parallel sampling of three target groups was used in the KPC : (a) mothers of children under 24 months of age, (b) women of reproductive age, and (c) the adolescent population. Two sample sizes of 210 interviews for each target group were drawn – one of the two Phase 1 rayons (Navoi and Kiziltepa) and a second sample population from the two new rayons (Konimeh and Nurata). The field team examined the results of the two pairs of rayons, as a group and separately. The purpose of the analysis was not to compare rayons but to develop recommendations for project implementation.

The standardized questionnaires were based on the KPC 2000 Child Survival and the Flexible Funds Guidelines. The Family Planning section was based on M&E guidelines

and instruments developed by the Population Council[2].

The objective of the baseline study was to provide Project HOPE and counterparts with baseline information at the household level.

Baseline Survey Findings

KEY INDICATORS: The Rapid Core Assessment Tool on Child Health (CATCH)	%	CI
Sentinel Measure of Child Health and Well-being		
1. Percentage of children age 0–23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)*		
Prevention of Illness/Death		
2. Percentage of children age 0–23 months who were born at least 24 months after the previous surviving child	48.3	±18.2
3. Percentage of children age 0–23 months whose births were attended by skilled health personnel	98.1	±1.3
4. Percentage of mothers with children age 0–23 months who received at least two tetanus toxoid injections before the birth of their youngest child**		
5. Percentage of children age 0–5 months who were exclusively breastfed during the last 24 hours	62.7	±9.0
6. Percentage of children age 6–9 months who received breastmilk and complementary foods during the last 24 hours	19.8	±8.2
7. Percentage of children age 12–23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday***	50.3	±7.2
8. Percentage of children age 12–23 months who received a measles vaccine***	88.1	±4.7
9. Percentage of children age 0–23 months who slept under an insecticide-treated net (in malaria risk areas) the previous night	No malaria areas	
10. Percentage of women of reproductive age who cite at least two known ways of reducing the risk of HIV infection	36.5	±4.7
11. Percentage of mothers with children age 0–23 months who report that they wash their hands with soap/ash before food preparation, before feeding children, after defection, and after attending to a child who has defecated		
Management/Treatment of Illness		
12. Percentage of mothers of children age 0–23 months who know at least two signs of childhood illness that indicate the need for treatment	48.6	±4.8
13. Percentage of sick children age 0–23 months who received increased fluids and continued feeding during an illness in the past two weeks	22.7	17.5±

* The survey did not include anthropometric measures

** The Uzbekistan MOH does not provide TT to pregnant women, only immunoglobulin to suspected cases of tetanus infection.

*** The MOH does not provide immunization cards to families; therefore, the above indicators were calculated based only on the mothers' recall.

The baseline study report **Annex E** shows the results of the Project HOPE activities in the four rayons, both collectively and separately, between the two pilot rayons (Navoi & Kiziltepa) and the two rayons that will begin activities in year 2004 (Konimeh & Nurata). The report also includes a discussion of recommended actions for the extension of the project.

[2] Guidelines and Instruments for Monitoring and Evaluation of Family Planning Services. Electronic Version 1.0. Copyright © 2000 by The Population Council. I. Mendoza, J. Foreit, N. Sloan, B. Pobiak, F. Leon, and J. Noble.

General Information

The following are the general characteristic of the three groups interviewed:

- All (100%) mothers of children under 24 months of age had some level of education, 7.9% only had primary education. The average age of interviewed women was 26.3.
- Also, all (100%) women of reproductive age had some level of education. Only 1.2% had only primary education, the rest had secondary education and higher. The average age of the women interviewed was 31.7%.
- Of the adolescents interviewed, 36.9% were boys and 63.1% were girls. School attendance was 80.6%, and the average age was 16.6%.
- 3.6% of the interviewees lived in urban settings and 96.4% in rural areas.

Breastfeeding and Infant/Child Nutrition

- 62.6% were breastfed within the first hour after birth and the exclusive breastfeeding rate was 62.7% for children 0-5 months of age.
- Breastfeeding initiation within the first hour after birth was 81.7% for the old rayons and 43.5% in the new ones; exclusive breastfeeding rate was 81.3% in the old Rayons and 48.4% in the new ones.
- 19.8 % of infants aged 6-9 months who received breastmilk, have also received solid foods in the 24 hours previous to the baseline survey; and 33.9% of children aged 20-23 months were still breastfeeding.

Childhood Immunization

- The Uzbek MOH keeps all immunization cards, so families do not possess any type of written information about their children's vaccination status.
- Expanded Program on Immunization (EPI) access (DPT1) was 96.2%, measles vaccination coverage was 88.1%, and EPI Coverage I was 50.3% by mother's recall.

Childhood Illness

- 48.6% of mothers reported at least TWO signs of childhood illness that indicate the need for treatment;
- 31.8% of children with diarrhea in the last two weeks, received Oral Rehydration Therapy (ORT); 15% were offered more fluids, and 19% were offered the same amount or more food during illness;
- 88.1% of children 0-23 months of age with cough and fast/difficult breathing in the last two weeks who were taken to a health facility or received antibiotics from an alternative source;

Maternal and Neonatal Care

- 99.8% of mothers had at least one prenatal visit on last pregnancy; and 54.1% had received iron supplements; nevertheless, the survey did not collect any data on the frequency and quantity of the iron supplementation intake.
- 98.1% of the deliveries were attended by a skilled health professional, and 69% of newborns were placed next to the mother immediately after birth;
- 76.9% had a post partum visit.

Reproduction and Child Spacing

- 48% of children were born at least 24 months after the previous surviving child;
- 70.5% of mothers started using a FP method after last delivery;
- 9.3% of WRA reported knowing that women are more likely to get pregnant halfway between two menstrual periods; and only 1.3% of the adolescent population reported to know that women are more likely to get pregnant halfway between two menstrual periods (1.9% for boys and 0.8% for girls);
- 72.6% of non-pregnant women who desire no more children in the next two years, or are not sure, are using a modern method of child spacing. The FP method mix was:

IUD	82.7
Withdrawal	3.3
Female Sterilization	3.3
Condom	2.6
Injectables	2.2
Standard Days Method	1.8
Lactational Amen. Method	1.8
Pill	1.5
Periodic Abstinence	0.7
Foam/Jelly	0.4

- 54.8% of adolescents reported that abortion is a common problem among teenage girls (52.3% for boys and 57.4% for girls)

STDs and HIV/AIDS

- 97.1% of WRA have ever heard of Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS), 76.7% of adolescents have ever heard of STDs in general and 97.8% have ever heard of HIV/AIDS specifically. The second highest percentage of STD knowledge in adolescents was syphilis with 12.3%.
- 36.5% of WRA reported to know of at least TWO ways of avoiding HIV/AIDS transmission (abstain from sex, use condoms, avoid contact with contaminated blood), and 54.1% of adolescents named at least ONE way to prevent HIV/AIDS transmission;
- 19.3% of adolescent stated they knew what a condom is.

b. Country Context

Uzbekistan is the most populated country in Central Asia; more than half of its 26 million people are concentrated in the south and east of the country. It is also one of the regions poorest countries. It is projected that the per capita Gross Domestic Product (GDP) is likely to fall from $350 to $250 for 2004 due to restrictive trade regime policies. While the Uzbek government claimed a 4.1% growth in GDP, in 2003, the U.S. Government believes it was no greater than 0.3%. [3] Unemployment and underemployment are high and employment and wage growth are stagnant. Although Uzbeks have attained a 97% literacy rate, the proportion of enrolled school-aged persons has been dropping. An

[3] http://www.state.gov/r/pa/ei/bgn/2924.htm

eroding education system has reduced Uzbekistan's advantage in human capital as grades and degrees are routinely purchased. As in the health sector, the supply of education materials and qualified personnel has suffered.

In September 1991, Uzbekistan declared independence and has since operated as a republic under President Karimov. Since the Soviet collapse, health care resources have declined, directly reducing accessibility to, efficiency of and quality within the health care system. Medical providers are often forced to seek alternative income sources to compensate for their meager salaries. Physicians for the Ministry of Health earn $20-22 a month and midwives and nurses, $13-15, on average. Facilities lack supervision and the continuing education necessary to provide health staff with new and improved knowledge and skills. They are often working on a knowledge base that is over a decade old without the equipment and drugs necessary to provide both preventive and curative services. Client passivity during the Soviet regime, which offered free drugs and comprehensive nurse outreach programs, still persists and enables pervasive preventable illnesses to persevere.

Presently, the Uzbekistan Government has been implementing a health sector reform with the assistance of various international and multinational organizations (World Bank, USAID and UK Department for International Development ((DFID) among others), while the country is cautiously moving towards a free market economy. In year 2002, the World Bank renewed a project to strengthening the primary health care in rural areas, which focuses in three Oblasts, Fergana, Navoi and Syrdarya[4]. The Zdrav Plus is a USAID-funded project designed to strengthen the health sector reform. Zdrav Plus, a close collaborative partner of Project HOPE in the region, seeks to improve the quality and efficiency of health services in five Central Asian Repulics. It supports the Government of Uzbekistan's health reform agenda, and in particular focuses on: (a) improving the efficiency of resource-use, (b) improving the quality of health care, and (c) redefining patient rights and responsibilities.

The health reform includes a 32% reduction in bed occupancy[5]. The hospital level health infrastructure remained essentially unchanged from what it was during the Soviet period. It is at the peripheral level, where basic health services are provided to communities, that most of the changes are taking place. For example, the number of health facilities has been reduced and the number of FAPs (feldsher, midwife posts) and SVPs (rural physicians' posts) increased or FAPs transformed into SVP services. In addition, the heath sector reform will provide continuous support for training family medicine doctors and the introduction of the new model for financing primary care.

The infant mortality rate continues to be a concern for the Uzbekistan government and cooperating agencies. The infant mortality rate of 1997, based on the Multiple Indicator Cluster Survey[6], was 37/1,000 live births, which is more than twice as high as the rate of

[4]http://lnweb18.worldbank.org/ECA/Uzbekistan.nsf/0/cdc97b44dbb4bc4a45256bc00025ed9c?OpenDocument
[5] UNICEF CARK. Situation Analysis Executive Summary. Almaty, 1999
[6] UNICEF CARK. Situation Analysis Executive Summary. Almaty, 1999

23.1 per 1,000 live births reported in official government statistics[7]. The difference in IMR reported by different sources is due to the fact that the Government of Uzbekistan did not adopt the WHO definition of live birth[8]. ARIs, diarrheal diseases, measles, anemia, and malnutrition account for 55% of the under five deaths; the remainder being due to perinatal conditions (19%), other infections (12%), noninfectious diseases (9%), and trauma (5%)). The very poor nutritional status of young children (12% of children under five are moderately to severely underweight and 84% are anemic) is an underlying factor in many infant and childhood illnesses and deaths[9]. According to the oblast health department, 12% of under five deaths occur at home, compared to 8% for all of Uzbekistan[10]. An additional 20% of deaths took place during the first day of hospitalization. By age 12 months, 85% of infants had received the eight recommended vaccines. As a result, the number of preventable infectious diseases has decreased in recent years.

The national maternal mortality ratio (MMR) is 34/100,000, and Navoi has a MMR of at least 73/100,000. The under-five mortality rate is 57 and 69 per 1,000 live births for females and males, respectively (MOH, 2000). The Demographic Health Survey (DHS) carried out in 2002[11], showed a total fertility rate of 3.2 for women 15-49 years of age (2.5 urban and 3.2 rural); and a general fertility rate[12] of 104 (86 urban and 116 rural). The total abortion rate (women of 15-49 years of age and expressed per woman) was 0.9 (1.1 urban and 0.9 rural). Finally, the percent distribution of currently married women using a contraceptive method was 67.7% for any method and 62.8% for modern methods (51.8 was for Intrauterine Device (IUD) that represents 82% of the method mix).

c. The Navoi Health Service Infrastructure

In addition to the sixth largest gold mine in the world, Navoi is home to significant chemical, pesticide and herbicide industries, due in part to a strong cotton production industry. Expansive and inefficient water irrigation for agricultural purposes has strained Uzbekistan's water supply, which reduced the Aral Sea to less than a third of its original size. The heavy industrialization of Navoi under Soviet rule, enabled the production of forty-six percent of the cement for the entire U.S.S.R., and with it, air and water pollution that pose significant public health problems in the region. Interestingly, however, the Navoi Oblast Governor (*Hokim*) reportedly subsidizes national contributions to the health delivery system through mandatory "contributions" from these factories. According to the Deputy of the Navoi Ministry of Health, 84% of the annual Oblast budget for health (some $1 million) comes from local contributions. Project inputs and humanitarian assistance are in addition to this amount. At the present time, Project HOPE appears to

[7] CCA Uzbekistan, HEALTH Chapter. DRAFT 002 of 5 May '03
[8] The Uzbekistan MOH considers newborns of less than 28 weeks of gestation and less than 1000 grams that do not survive the first six days as stillbirths.
[9] Oblast Health Department, 2001.
[10] NPRI, 2001.
[11] Uzbekistan Health Examination Survey 2002. Preliminary Report. Ministry of Health of Uzbekistan, State Department of Statistics, MEASURE DHS+ ORC Macro. May 2003.
[12] General fertility rate (births divided by the number of women age 15-44) expressed per 1,000 women

be the only International agency with a program in the Oblast, though Asian Development Bank (ADB) and the World Bank loans will provide infrastructure support in the near future.

Currently, in Navoi as throughout the country, health professionals are enormously underpaid (Rural doctors make $25/month with the per capita GDP at $2500). As a result, most have private, parallel practices to their government employment. Cut off from innovations in medical best practices until the 1990s, providers are eager to learn and adapt international approaches in medicine and public health. The first phase of the project showed the health provides supported by the Project were very receptive to learning more about public health issues that are relevant to their lives.

The Uzbekistan MOH structure at the Oblast level is based on specialties by levels of care (e.g., pediatrics, OB/Gyns, etc.) At the Oblast level, the hospitals receive all referrals by specialty. The rayon level maintains a similar structure, rayon level hospitals by specialty, and the primary health care infrastructure is formed by a series of health facilities that may have some differences in functions. The Navoi health infrastructure, and specifically the four project rayons, is shown in the following table.

	Navoi city**	**Navoi rayon**	**Kiziltepa rayon**	**Konimeh rayon**	**Nurata rayon**
Oblast Maternity House: Provide services to the entire Oblast (Ob/Gyn service for Navoi city, and emergency care and referrals of all Rayons	1				
Oblast Child Hospital: Medical services for children under 14 years of age for entire Oblast	1				
Central Rayon Hospital: Medical services as well as Ob/Gyn service for Rayon population			1		1
Central Rayon Hospital with policlinic: Primary and secondary health care for rayon (PHC services and by specialty)		1		1	
Central Rayon Polyclinic: PHC services and by specialty for adult and children populations			2		2
Rural Hospital (SUB): Medical and Ob/Gyn services for part of rayon.			2		5
SVP: PHC services by GP's, nurses and midwives for village/Makhallah population		16	21	10	10
SVA: PHC services and some specialties (pediatrics and Ob/Gyn) for village/Makhallah population.		1	5		4
FAP*: Medical services for remote village/Makhallahs, attended by feldshers			3	15	12

* The MOH does not list FAPs, but there are still several active in the Navoi Oblast.
**Not all health facilities in Navoi city are listed, because Navoi city is not considered as project area, and the project will only work with Oblast Maternity House and Oblast Child Hospital as training centers.

The medical services by specialty are clinically or curative oriented. The health services have a geographical area assigned, and all inhabitants are registered for medical attention or for specific health services delivery. Oblast- and rayon-level health facilities are administered by the oblast and local governments. If a family moves to another community, the health service will send the health records of each member of the family to the assigned health service. Managing the health portfolio based on results oriented

objectives and indicators, and program performance is at an early stage, as the whole system is being gradually "westernized" by means of the health reform. Quality of care, client satisfaction, demand for services, monitoring performance of service delivery, etc., are new concepts for the majority of the MOH health staff, as well as community mobilization strategies, IEC-Counseling and adult education methodologies.

Access to health services and coverage are extremely high. People in general, have access to free-cost health services, and there are no private practitioners in rural areas or small communities. The health information system has records of every member of the families by communities. All health events are recorded by the primary health care system or at the hospital level. For instance, the immunization program keeps all vaccination records at the health service level. Data tabulation and analysis does not happen regularly, and there is not enough decision making based on quality data.

The following tables shows the health personnel who will be involve in the project:

Health Personnel	Project Rayons				Total
	Navoi	Kiziltepa	Nurata	Konimeh	
First link doctors (GPs and pediatricians)	44	60	44	14	162
Midwives*	69	132	80	29	310
Nurses (neonatologists and Ob/Gyn department)**	32	54	19	23	128
Patronage nurses (home visits)***	103	108	261	82	554
Feldshers****	43	20	104	7	174
Total	**291**	**374**	**508**	**155**	**1328**

**Midwife*, 3 years of college education. Responsibilities are attention of no-complicated Ob/Gyn's procedures in hospital level and PHC level.
** *Nurse (neonatal)*, 3 years of college education. Responsibilities are to work with Neonatologyst in Maternity House or Child hospital and provide health services only to newborns.
****Patronage nurse*, 3 years of college education. Responsibilities are visiting nurse to home. They will work 3 hours at SVP and 3 hours visiting time to houses.
***** *Feldsher*, 4 years of college education. Responsibilities are to provide health services at the PHC services in FAP where there is no doctor. Feldshers are allowed to prescribe antibiotics. He/She is between doctor and nurse.

2. Program Description

a. Local and National Partners

Navoi Oblast Health Department. All activities under this project will be carried out through and in close collaboration with the Oblast Health Department (OHD). The OHD and its subdivisions (Oblast Maternity House, Oblast Child Hospital, Reproductive Center, Adolescents' Center, IMCI Center, Rayon Health Departments, and Oblast Health Institute) organize, plan, and manage health prevention activities in oblast. OHD is responsible for planning health prevention activities; collecting and analyzing monthly, quarterly, and yearly reports on work carried in all health facilities in the Oblast; and giving recommendations to health prevention facilities on improvement of work quality. These reports are collated by the OHD and given to the MOH and Republic Informative Center. The OHD also oversees health provider continuing education, quality of care, and

performance for the Navoi Oblast. The technical offices – such as the Reproductive Health Center and the Health Institute – house local experts that organize trainings and promote health outreach activities in their particular fields. In addition, the OHD supervises IMCI, SM, and Adolescent Reproductive Training Centers, which have been and will continue to be developed and supported under this project.

Navoi Oblast's Administration (NOA). The NOA and its subdivisions (rayon administration and makhalla, committees) oversee and "monitor" all community activities carried in the rayons and Navoi City – for instance manufacturing and construction, population training, and improvements in local conditions (health, cultural and, socio-economic). Through coordination with the NOA and the OHD, Project HOPE will continue to work closely with makhalla leaders to involve them in the approval, planning, and training of community-based MCH and FP education activities with community members.

Ministry of Health Department of Uzbekistan. Project HOPE has long standing relationship with the MOH, beginning in 1998 with the onset of a large TB project. (Please see Memorandum of Understanding with Uzbek Government in **Annex G**). Before the OHD, Project HOPE and other PVOs can introduce and carry out interventions based on international protocols, the MOH must pass *prikazes* (or government decrees) that require OHDs to comply with the international protocols. For the new project, all proposed interventions have been approved and are firmly established by the MOH, with the exception of Safe Motherhood/ Promoting Effective Perinatal Care (PEPC.) Although the WHO-based strategy has been approved, the protocol continues to be adapted at the national level by the MOH and international NGO working group. Project HOPE is an active member of the IMCI, SM, and BF working groups and staff members attend regular meetings in Tashkent. Within the MOH in Tashkent, a number of offices or institutes serve as technical arms of the MOH. One such office is the *Tashkent Scientific Research Institute of Pediatrics* that provides the MOH with technical input, scientific studies, and new methods for carrying out effective child health interventions in the country. The office coordinates IMCI and BF activities in the country.

Synergies With Other Project HOPE MCH/RH Projects in the CAR region. The Navoi CS project was a model for the design of USAID/CAR's *Healthy Family* bilateral program covering two other oblasts in Uzbekistan. In addition, Project HOPE is implementing a "sister" CS project in Kyrgyzstan. Navoi's best practices have been incorporated into the design of the bilateral and Kyrgyz projects. Operationally, the Navoi Project shares human and financial resources with both the bilateral project and the CSHGP Kyrgyzstan project in developing and printing training curricula and IEC materials. Likewise, a constant dialogue regarding effectiveness of current practices flows between the projects through various forums: Project HOPE regional workshops, Annual Fall Leadership conference, internet communication, yearly "interchange" visits, and by frequent feedback from the headquarter-based Program Manager, who backstops all MCH programs in the regions and facilitates the dissemination of lessons learned from all projects. There is also a great deal of support on the part of the bilateral project for helping Navoi support administrative needs that needs to be carried out in the capital city

of Tashkent. The CS project in Navoi will continue to serve as a "laboratory" for the other programs as well as repository for lessons learned that could be used in other programs.

Other National/International partners: WHO, UNICEF, UNFPA, and Zdrav Plus. Project HOPE and the Uzbekistan MOH collaborate nationally with WHO, utilizing their international protocols for IMCI and PEPC. UNICEF and UNFPA are partners on the ground. They have collaborated with drugs and contraceptive supply and Project HOPE shares materials with them and uses their materials for health outreach. Zdrav Plus, another USAID contractor, works closely with Project HOPE at the national coordination level and locally on the ground in Navoi, where resources are shared in the creation and dissemination of IEC materials.

Other local partners: Local NGOs that include: (a) the Women's Social Adaptation Center, (b) **"**Healthy Generation" Foundation of Navoi, (c) the Makhallah Foundation of Navoi Oblast, and "Tumaris". The Project is working with and through these local NGOs to train the target adolescent population in carrying out surveys, developing IEC materials, conducting trainings, and carry out follow up monitoring/supervisory visits. Other very important local partners are leaders in the community (makhalla committee leaders, grandmother leaders, religious leaders), primary health facility providers who live and work in the communities, schoolteachers and adolescent peer counselors.

b. Capacity Building

The Project HOPE CS project will upgrade the technical and managerial operations of the OHD and its own staff to provide a better quality of health promotion and care in the pilot rayons and throughout the Oblast. The capacity building approach will be to strengthen the health service functions. Although the DIP includes a number of training courses and training activities, the project will emphasize the extent to which the graduates provide technically appropriate and culturally acceptable services instead of concentrating on number of trainees or the results of pre-and post-training scores. In order to achieve this, the OHD and Project HOPE staff will work with facilities and former trainees on an individual basis targeting upgrading of deficiencies identified in external or self-assessments providing quantitative and qualitative data, engaging in joint analysis, decision-making, and corrective action on a continuous basis. The project also will expand the role of the existing steering committee and will develop proactive technical working groups formed to solve problems and improve the overall system of MCH/RH care in the oblast. The project will work with the steering committees to determine which issues will be better dealt with via group activities at regional level, and which issues will benefit from individual support.

i. Steering Committee

Under the auspices of this project, Project HOPE, OHD and the Makhallah management team of the NOA developed a steering committee (SC) in the pilot rayons. Public, and some of the private sector, organizations working in the Navoi

Oblast were members of the SC and were involved in enforcing key health interventions and quality improvement monitoring strategies. The SC met regularly in Phase 1 to review the DIP, annual plans, and to define the contributions of each member. The purpose of the SC is to increase inter-agency collaboration, commitment to CS/SM/RH and to reduce duplication of efforts, while strengthening the leadership role of the Ministry of Health in a sustainable way. In the new project, HOPE will continue and expand the role of the SC by including representatives from the new rayons, national and local NGO partners, and representative community leaders.

ii. Technical Working Groups

Members of the SC will initially develop four multi-disciplinary taskforces, or technical working groups (TWG). The TWGs will be comprised of SC members and other outside technical representatives who have relative experience to the TWG. Their members will be technical experts, managers and decision makers in the field of MCH/RH, and community members. The primary purpose of the working groups will be to provide a forum for technical oversight and troubleshooting problems that affect the overall quality of the health care under the supervision of the OHD. The four TWGs will be:

- **Training and Education Working Group (TEWG).** The TEWG will support the implementation of the project's training agenda. Members of the TEWG will be Project HOPE staff, chief trainers of the oblast and rayon levels, and other technical experts. The TEWG's responsibilities will be to: (1) review the training curricula, approaches, and materials for health facility staff; (2) maintain a data bank of staff and the training they have received, including individual pre- and post training tests scores; (3) provide technical support to the rayon and Makhallah level trainers; and (4) take an active role in mentoring monitors/supervisors to give onsite training related to quality and performance issues during monitoring visits. The TEWG will work with assigned consultants to develop new community-based initiatives as well as diagnostic and operations research activities. The TEWG will also participate in assessing training activities and modifying training curricula and training plans based on the results of monitoring and assessment activities. This group will be responsible for designing and organizing trainings to update already trained health providers to the new international protocols.

- **Quality Assurance and Improvement Working Group (QAIWG).** The QAIWG will support M&E activities geared towards decision making and ongoing quality assurance and improvement activities. The QAIWG will promote quality awareness at all levels of the health system. Members of the QAIWG will be Project HOPE staff, statisticians and department chiefs of the Oblast and rayon levels. The QAIWG responsibilities will be to: (a) review the results of monitoring: HIS and evaluation activities; (b) identify both technical areas of weakness and facilities with clusters of quality and performance issues; (c)

monitor the effects of interventions relative to client needs, strategies, and implementation and institutionalization processes, both individual and group/regional interventions; and (d) document the overall achievements of the project. The current HIS and Project HOPE's M&E tools and instruments will be integrated more effectively under the QAIWG guidance. Because training and support in data analysis and interpretation of the results will be needed over the course of the project, the members of the QAIWG will be the primary recipients of the upcoming Technical Assistance in Quality Improvement workshop. In addition, Project HOPE will coordinate and collaborate with the *Health Family* project in Tashkent. *Healthy Family* has a strong HIS component, and its resources and strategies can be shared with the QAIWG for their mutual benefit.

- **Management and Logistics Working Group (MLWG).** The MLWG will be responsible for improving and assuring the functionality of the support systems (i.e., procurement and distribution systems); and equipment maintenance and repair. The group will be comprised of chief doctors from the rayon level, OHD officials, and Project HOPE staff. The primary focus of the MLWG under this project will be to monitor the essential drug supply and the condition of necessary equipment pertinent to carrying out the IMCI, PEPC, and RH protocols effectively. This group will receive data from the reports assessing the health facilities gathered during the monitoring visits, analyze the results, and make recommendations to the rayons for budget planning based on their needs. The recommendations are intended to facilitate focusing scarce resources appropriately and to educate the OHD on the supply and demand needs of the secondary and primary health facilities.

- **Behavioral Change and Communication Working Group (BCCWG).** The BCCWG will assist in: (a) designing behavioral change strategies, assessing the population needs, (b) determining the means of formal and informal communication, and (c) designing IEC materials and job-aids. Members of this group will be staff from the Health Institute's Navoi branch, Project HOPE staff, local NGOs, and community representatives. The group will be responsible for managing a resource "library" of health education materials produced in the country and internationally. The BCCWG will also adapt, design, and pilot test IEC materials in the field. Lastly, the group will help plan and carry out campaigns specific to MCH interventions.

iii. Strengthening of Project HOPE Staff

Due to the increased need for Project HOPE technical team assistance, the staff will participate in a series of technical meetings, workshops, and training activities designed to increase their skills in child and reproductive health, project management and monitoring and evaluation methodologies. Three of the proposed activities are:

LQAS. The technical team already participated in a LQAS training in Tashkent in collaboration with the *Healthy Family* project. Training and assistance, however, will

still be needed for the first LQAS exercise in order to strengthen the data collection tools, data analysis, and use of the results for improving service delivery and promotion.

Community-Based Strategies. The project will use an external consultant to develop and field-test community-based strategies and methodologies for health education and promotion.

English and Computer Classes. Project HOPE will help staff obtain an increased certain proficiency in computer and English skills at a minimal cost to the project.

c. Objectives, Interventions and Activities

The project HOPE team has evolved technically and new staff was added in order to carry out this follow-on project. Project HOPE will continue providing technical support by means of: (1) training oblast/rayons' staff in key child survival and reproductive health interventions; (2) adapting, field-testing and expanding standard case management protocols; (3) developing and field-tested training curricula, (4) developing a Makhalla-based strategy by identifying Makhalla-level organized groups and leaders and training them in key health interventions, and (5) improving monitoring and evaluation at the service and community levels.

The following are the *direct* target population by rayons.

Beneficiary Populations	Rayons				Total
	Navoi	Kiziltepa	Konimeh	Nurata	
Children 0-5 years of age	10,253	12,038	3,654	10,771	36,716
Women of Reproductive Age (15-49)	18,778	30,581	9,610	18,510	77,479
Adolescents (15-18 years of age)	7,200	8,800	3,087	6,418	25,505
TOTAL	**36,231**	**51,419**	**16,351**	**35,699**	**139,700**

The following table shows the percent effort by the various health interventions.

Intervention	% of Total Effort
IMCI: ARI/Pneumonia Control	10%
IMCI: Control of Diarrheal Diseases	10%
IMCI: Child Nutrition	10%
Breastfeeding Promotion	10%
Family Planning	30%
Safe Motherhood/Newborn Care	30%

INTERVENTION SPECIFIC APPROACH

i. IMCI: ARI/Pneumonia Control (10%); Control of Diarrheal Diseases (10%); and Child Nutrition (10%)

Objectives: (1) Increase the proportion of mothers recognizing fast breathing and chest indrawing as signs of pneumonia; (2) Increase the proportion of children with signs of pneumonia who were assisted by a trained health provider; (3) Increase the ORT use rate; (4) Increase the percentage of mothers who recognize danger and dehydration signs; (5) Increase the percentage of mothers who give the child more/equal amounts of liquids during diarrhea; (6) Increase the number of mothers who continued feeding the child during a diarrhea episode; and (7) Increase appropriate complementary feeding practices after six months of age; i.e., quantity and quality of foods, breastfeeding first then foods, and introduction of micronutrients (Fe, iodine and Vitamin A.)

Main activities: Project HOPE will improve the access and quality of child health services by emphasizing health education and preventive measures at the home level; ensuring that health providers give quality services by means of standard IMCI protocols; and supporting and adapting new initiatives to improve quality, access and coverage of services (i.e., community mobilization, male and grandmother involvement). For this next Phase, HOPE will carry out the same IMCI training activities carried out under phase 1 in the new rayons and will train any appropriate health providers in the old rayons who previously were not trained in Phase 1. The new rayons will benefit from the experiences from the old rayons, which will also serve as models for experience and observations for health providers in the new rayons. Project HOPE will carry out focused quality improvement activities responsive to facility and provider needs and circumstances, in group mode or individually, educational (training) or motivation and technical support, and will develop a comprehensive health education strategy for the communities.

Training curricula and training plan: The first activity the team will carry out is to train and refresh appropriate health providers from pilot rayons in the 11-day WHO standard IMCI training and a 3-day course based on the translated Community- IMCI (C-IMCI) training curricula.[13] Priority topics will include:

- Evaluating the child to determine: (1) pneumonia in children with a cough or difficulty breathing, (2) dehydration and complicated diarrhea signs and symptoms, (3) nutritional practices, and (4) the status of vaccinations.
- Classify children's illnesses as to: (1) acute illnesses, acute pneumonia, pneumonia or no pneumonia; (2) diarrhea with dehydration (severe or not severe) or diarrhea with complications or diarrhea without dehydration; (3) nutritional status (healthy or mild, moderate or severe malnutrition); and (4) immunization coverage (timely and complete or not).
- Treatment of illnesses and appropriate, timely follow-up.

[13] Refresher courses will be condensed to fewer days, depending on analysis of monitoring visits.

- Parental counseling on treatment and prevention.
- Immediate referrals to health centers and hospitals for more severe cases.
- Clinical charts and information registry.
- Include a section on adult education methodologies.

Project HOPE will carry out a 5-day Training of Trainers (TOT) for general practitioners and pediatricians[14]. Twenty trainers who have been already trained will receive refresher training, and 20 more will be trained for the new rayons.

For all IMCI trainings, as for all trainings sponsored by Project HOPE under this project, pre- and post-tests will be administered to trainees to measure short-term success relative to the participant learning curve and trainer's didactic skills.

Two-hundred and three general practitioners, pediatricians and feldshers will be trained using the standard WHO 11 days training framework[15], and 470 primary health care workers (patronage nurses, nurses and midwives) will be trained in a 3-day adapted IMCI course[16]. Trainings will all utilize participatory educational techniques. Project HOPE will also incorporate lessons learned from the HF Project, where staff are developing and field testing a module on adult education methodology.

The project will use the IMCI training center that was installed at the Navoi pediatric hospital during the previous project to carry out most of the TOT and some 11-day courses. Training of primary health care staff will be carried out in the Central Rayon Hospitals. A specific training plan will be developed by the IMCI training center and facility. Finally, Project HOPE will create two new training centers/rooms in the new rayons at the central rayon hospitals[17]. Trainers formed under Phase 1 will be utilized to conduct trainings in new rayons and encouraged to share their experiences with health providers from the new rayons.

Makhallah/Community-Based IMCI: In Phase 1, Project HOPE staff disseminated the key 16 WHO/UNICEF family practices through health education and IEC materials. For Phase 2, Project HOPE will contract an external consultant with expertise in community mobilization and adult education to help develop a training curricula and a training plan for work in the communities. The project will work closely with members of the BCCWG and rayon primary health care workers (patronage nurses and feldshers) to develop and disseminate messages in a Makhallah-based MCH strategy, which will consist of key messages to support IMCI. Health workers, particularly outreach "patronage" nurses will also be targeted to

[14] Manual for teachers on modules - WHO/UNICEF, Health Ministry of Republic of Uzbekistan, 1998
[15] IMCI "Examination and classification of a sick child at the age from 2 months till 5 years – WHO/UNICEF, World Health Organization, Health Ministry of Republic of Uzbekistan, 2000
[16] Training manual on C-IMCI for patronage nurses - Tashkent, Republican Institute of Pediatrics, WHO/UNICEF, 2002
[17] The rayon health facilities have not been renovated since at least the collapse of the Soviet Union in 1992. Creation of training rooms in the Central Rayon Hospitals involves general repairs to one or two rooms, painting walls, and purchasing tables and chairs for trainings.

receive training or orientation as to how to work at the community level and to carry out health education. This strategy will be multi-sectoral at the ground level and will be targeted towards the following community members:

- *Grandmothers.* Elder women, grandmothers and community leaders such as *Mullah-Bibis* (female religious leaders) are usually present at weddings and when children pass from the mother's side to the cradle, so they are perfect to provide first hand counseling on key child protective behaviors. Project HOPE has carried out a diagnostic study of the grandmothers' involvement[18] that gave recommendations on how to develop an effective and appropriate community-based intervention. Project HOPE will continue with this consultancy to fully develop community-based activities.
- *Makhallah leaders, particularly the female leaders,* who can also be trained to provide health education and counseling at the community level. Makhallah leaders usually work in close collaboration with the health services, and their functions are to enforce MOH health programs, community organization and link with the local health service.
- *Male community members.* Project HOPE will also carry out a diagnostic study to determine males' involvement in childcare. Based on the study results, it will define interventions to involve men in child's care and health education (please refer to the M&E section to see possible operations research activities). One such intervention might involve targeting *Mullahs* (Male religious leaders) who deal less with health and family issues, but have a powerful influence on the male members of the community

Behavior Change Communication (BCC): As described above, the BCC strategy at the community level will continue to target messages from some of the IMCI's 16 key practices designed to foster the growth and development of healthy children less than five years of age[19]. Materials designed by funds from Glaxo Smith Kline in Phase 1 will be updated and used in Phase 2. In particular, the baseline indicates a need for more education with respect to the signs of dehydration and determining when a child has a complicated diarrheal disease and needs medical attention. The baseline also shows that families recognize respiratory difficulty as a symptom of serious illness, but they do not associate it with pneumonia. The project will clarify the key indications that determine if a child has pneumonia and needs medical attention. Finally, to strengthen the work that Project HOPE already initiated in newborn nutrition (i.e., exclusive breastfeeding), the baseline report shows that in this project, efforts must also focus on educating families to introduce solid and semisolid foods by means of weaning the child with quality foods and micronutrients (iron,

[18] Report on "The Role of Grandmothers and other household actors in maternal and child health. A qualitative community study." Project HOPE Navoi, Uzbekistan. July 2003. J. Aubel, PhD, MPH, Consultant ; N. Muratova, MD; N. Bosorova, Midwife; L. Djelilova, MD, IEC; D. Allabergenova, MD; N. Shaymanov, MD; and A. Kuchimov, MD.

[19] Series HCT/AIEPI 62(3).I. WHO and UNICEF, Integrated Management of Childhood Illness, IMCI. 16 Key Family Practices. Pan American Health Organization, Division of Disease Prevention and Control/Communicable Diseases Program/Integrated Management of Childhood Illness IMCI; American Red Cross, International Services, International Health Program, Integrated Management of Childhood Illness IMCI.

iodine and Vitamin A).

At the health facility level, emphasis on quality improvement of monitoring and supervision will strengthen BCC activities. The project will promote immunization education and will urge the Oblast Health Department to allow families to possess some type of EPI card. Likewise, the project will strengthen the monitoring and logistic systems of the OHD to assure the constant availability of the essential drugs and medicines.

Quality Issues: Project HOPE is committed to implementing a client focused approach to providing child health information and services in ways that directly respond to the perceived needs and expectations of the population. Issues of full and balanced information through quality counseling will also be important elements when training health workers. In terms of Monitoring and Evaluation (M& E), Project HOPE's approach will be to work with the Steering Committee and its subsequent working groups in order to promote an identification, prevention and problem-solving focus that should allow continuous improvement in the quality of care. The project will also assist IMCI trainers to monitor its implementation and the quality of service delivery. According to WHO IMCI protocol, recent trainees of the IMCI curricula should be monitored one month after being trained to see if they are carrying out the new protocol accurately and, if not, to conduct quality refresher training on site. The project will do this as well (i.e., trainees will receive their certification for IMCI training in the field only after this monitoring visit and if they pass by scoring 85% or above on the checklist protocols). If the health trainees do poorly on the monitoring visit, the monitor will work with the health provider to review the training and revisit the health provider on a surprise-monitoring visit in the future. Every 6 months after being trained in IMCI, Project HOPE will monitor a sample number of trainees using LQAS methodology to see how IMCI is being implemented and to feed this information into OHD and the QAIWG.

ii. Breastfeeding Promotion (10%)

Objectives: (1) Increase the percentage of mothers exclusively breastfeeding their infant for the first six months; (2) Increase the percent of children receiving BF during the first hour of birth; (3) and Increase the percent of newborns that are put skin-to-skin contact with mother immediately after birth, and for at least 30 minutes.

Main activities: Project HOPE will improve the quality of the mother and newborn care by complying with the Baby-Friendly approach[20]. Health education will focus on breastfeeding practices at the family level. In the old rayons, Project HOPE, in collaboration with MOH and UNICEF, will focus on maintaining good ratings and the re-certification of facilities already in the Baby-Friendly Initiative. Health providers and all staff from the new rayon maternity houses will be trained in the Baby-Friendly methodology and go through the certification process. At the end of

[20] Tools on conducting monitoring and evaluation for WHO/UNICEF Initiative on creating "Baby friendly clinics", WHO/UNICEF, August, 1992.

the program, the goal is that all maternity houses in the pilot rayons will be certified or have been recertified.

Certification of Baby-Friendly Hospitals: This international initiative is based on the WHO "10 Steps to Successful Breastfeeding"[21]. The recertification process occurs every 2 years and is carried out by MOH central level and UNICEF. Project HOPE will continue to use the standard WHO manuals for trainers and participants[22], which have been translated into Uzbek from the Russian by Project HOPE. The total number of health staff to be trained is 699, which are drawn from Ob/Gyn, GPs, midwives, feldshers, nurses and patronage nurses. Project HOPE will carry out training and refresher training in close collaboration with the OHD, and every six months each maternity house will carry out training sessions for new staff.

To date, the Baby-Friendly Hospital initiative has only been applied to the maternity houses at the Oblast and Rayon levels in pilot rayons, but the MOH, the National Pediatric Research Institute, international NGO representatives (including Project HOPE) and their colleagues in the national multi-sectoral Baby-Friendly Working Group have been discussing with WHO the possibility of expanding Baby- Friendly Certification to Children's Hospitals. When the package on client-focused "Mother and Child Friendly Clinics" is developed at the national level, Project HOPE will explore the possibility of expanding focus to include the Children's Hospitals in the pilot regions.

Breastfeeding Support Groups: The FE of the previous project concluded that these groups were highly successful and should be expanded. Maternity houses hold regular meetings with mothers' support groups (MSG), community facilitators and activists. The objective of theses meetings is to educate mothers on breastfeeding and child health in general. Project HOPE will expand this work to the SUB(rural Community hospital), SVP and FAP levels thereby involving midwives and feldshers.

BCC and Makhallah/Community-Based work: Project HOPE will also add breastfeeding when developing an intervention with grandmothers and Mullah-Bibis and other community leaders. The intervention will first be carried out on a pilot basis, and then it will be up-scaled based on the results and lessons learned from the pilot experience.

Once a year, Project HOPE will participate and endorse the "Breastfeeding Week," which is organized and implemented by the MOH and collaborating agencies. During that week, there are mass media messages and health fairs at the Makhallah

[21] 1. Follow fixed BF rules and have health staff and women in childbirth know them; 2. Train medical staff to be more skilled on BF practice; 3. Provide Information to all pregnant women on BF advantages and technique; 4. Help mothers start BF during 30 minutes after delivery; 5. Show mothers how to breastfeed and save breast milk if separated from their babies; 6. Do not give babies any food or liquid but only breast milk unless there are medical reasons not to breastfeed; 7. Encourge the practice of mothers and babies staying together all the time; 8. Encourage BF on demand, not on the schedule; 9. Do not give BF babies sedatives and nipple/breast substitutes; and 10. Encourage organization of BF support group and direct mothers to these groups prior to discharge from the maternity house or hospital.
[22] Counseling on Breastfeeding. WHO/CDD/93.4. Training manual and participants manual.

centers. Also, during the "Breastfeeding Week" Project HOPE will continue to organize competitions directed to breastfeeding mothers and families.

Finally, the FE found that mother support groups (MSG) were well accepted by community members. The project will provide TV and VCR sets to the new rayon maternity houses and the FAPS where the OHD expands the MSG work. Video tapes, which were developed and field tested by *Healthy Family* Project and UNICEF (translated into Uzbek by Navoi CSHGP), will be shown on VCRs in the maternity houses during training of health providers and other community leaders and for new mothers to view.

Quality: Like other WHO protocols, the Baby-Friendly Hospital Certification protocol comes with a series of monitoring requirements that in turn have been adapted to local needs. The monitors trained in Phase 1 to carry out Baby-Friendly monitoring will continue to visit maternity houses two months and 6 months after maternity house health providers have been trained in the methodology. They will use the series of instruments, exit interviews and checklists provided by WHO to see what progress is being made in becoming a Baby-Friendly service site. The National Certification team from Tashkent will be invited approximately one year after all health providers have been trained. The health facility will be certified based on their compliance with WHO's "10 steps" guidelines. Once a maternity house has been certified, the monitoring teams will continue making sure that the health facilities continue to follow the Baby-Friendly protocol. Recertification takes place every two years. All monitoring reports will be shared with the QAIWG where the information will be analyzed. In the past, the SC took great pride in this certification process and most members were present at the certification awards ceremony. Project HOPE expects this support to continue.

iii. *Safe Motherhood/Newborn Care (30%)*

Objectives: (1) Increase the number of mothers who received/buy iron supplements while pregnant; (2) Increase the percent of mothers who had at least one postpartum check-up; and (3) Increase the percent of mothers who know the danger during pregnancy, delivery and postpartum that indicate the need for treatment.

Main activities: The project will: (1) aim to improve the access and quality of safe motherhood services in the target rayons, (2) ensure that health facility health workers provide quality services; and (3) support and adapt new initiatives to improve quality, access, and coverage of Safe Motherhood services.

The main intervention strategy will follow the WHO PEPC (Promoting Effective Perinatal Care) approach. PEPC will be introduced by a 9-day course to health providers (Ob/Gyns and midwives). The training package will include a manual for trainers (developed by WHO and adapted by the PRIME II Project), an information guide and training aids for course participants. National protocols for PEPC had not been established until the recently passed (2004) Prikaz #500 that calls for

international guidelines in Safe Motherhood. Relevant health providers from new rayons will be trained for the first time in PEPC under the current protocol ordered under prikaz #500. Providers trained in Safe Motherhood (SM) under phase 1 will be updated to these new protocols in Phase 2 refresher trainings.

Training plan: The project will carry out TOTs and then train health staff on Safe Motherhood. The priority topics will include:

- Pregnancy care: (1) identifying high-risk pregnancies, (2) providing TT vaccines and immunoglobulin, (3) administering iron folate, (4) FP counseling, (5) scheduling births at health services and preparing for potential emergencies, and (6) orienting new parents
- Labor and delivery care: (1) care for normal births, including active management of the third stage of labor, (2) use of the partograph, (3) psychological support during labor, (4) identifying signs and symptoms of obstetric complications and need for immediate care/referral, (5) care of the newborn, (5) management of asphyxia of the newborn; (6) place the newborn skin-to-skin with the mother, and (7) invite the father/family member to be present during the delivery for support.
- Postpartum care: (1) LAM and nutrition for nursing newborns, (2) FP counseling, and (3) child health care
- Neonatal resuscitation course for neonatal physicians[23].
- Follow up and home visits
- Nutrition for the pregnant and lactating women.
- Health information systems and information management.

Curricula: Training of trainers will be carried out based on an AVSC[24] and PRIME II manuals[25]. 15 trainers will be developed for the new two rayons. Then the project will carry out a 9-day courses directed to 222 OB/GYNs, midwives of the Central Rayon Hospitals (CRH) and Rural Hospitals (SUB). A detailed training work plan will be developed to specify the number of training sessions. In addition, the project will carry out a series of 5-day courses directed towards neonatologists, nurses of CRHs and SUBs. Finally, a series of 6-day training courses will be carried out to train a total of 551 midwives, GPs, nurses and feldshers of SVPs, SVAs (rural physician ambulatory clinics), and FAPs.

Training of trainers and some training sessions will be carried out at the Oblast

[23] Reanimation neonatal (Skills book for instructors), American Heart Association. American Academy of Pediatrics. 2000. Authors Neil Finer, MD,FAAP; Joseph Finer, MD,FAAP; Susan Niermeyer , MD,FAAP; Joseph Zennel , MD,FAAP.

[24] TOT: A manual for Trainers of Reproductive Health. AVSC International, 1996

[25] Trainers Guide on "Management of Normal pregnancy, Normal deliveries, Postnatal Period and Prevention of Complications", Uzbek and Russian versions, PRIME II/Intrah, 2003.

2. Participants Guide on "Management of Normal Pregnancy, Normal Deliveries, Postnatal Period and Prevention of Complications", Uzbek and Russian versions, PRIME II/Intrah, 2003.

3. Information Guide on "Management of Normal Pregnancy, Normal Deliveries, Postnatal Period and Prevention of Complications", Uzbek and Russian versions, PRIME II/Intrah, 2003.

4. Training slides on "Management of Normal Pregnancy, Normal Deliveries, Postnatal Period and Prevention of complications", Uzbek and Russian versions, PRIME II/Intrah, 2003.

Maternity House Training Center in Navoi City. The training center will carry out the same functions as the IMCI training center, only with a focus in coordinating the SM activities for the Oblast. The rest of the training sessions will be carried out at the rayon level, rayon maternity houses and rayon hospitals.

BCC and Makhallah/Community-Based work: At the health facility level, similar to the IMCI intervention, the emphasis of the SM/BCC strategy will be improving provider knowledge and practice of the SM protocol, and in particular, how essential information is conveyed to patients. Change in provider behavior will be monitored in quality supervisory and monitoring visits. The SC working groups will be agents for facilitating changes that help a health provider carry out the PEPC guidelines. For instance, the QAIWG will analyze the primary health facility monitoring reports to determine what essential OB/GYN/neonatal supplies and medicines, case management protocols, and IEC/counseling materials are available in the health facilities.

At the Makhallah level, Project HOPE will carry out an integrated Makhallah-based MCH strategy, which will consists of key messages in prenatal, delivery, neonatal and postpartum care. The strategy, as mentioned previously in the section on IMCI prevention, will target natural leaders in the communities – grandmothers, Mullah-Bibbis, and male leaders. Since most obstetrical complications occur when a woman is already under the care of a health provider, key messages for the community members will focus on those specific to the prenatal and postpartum period (e.g., the importance of taking iron supplementation during pregnancy or exclusive breastfeeding postpartum).

Quality: Project HOPE will focus on improving the quality of SM service delivery through close monitoring and supervision of the service delivery and the Makhallah levels. Complete information about prenatal, delivery and postnatal care will be based on quality counseling and the delivery of quality messages through health facility and community based health workers. As stated in previous sections, Project HOPE is committed to implementing a client-focused approach in SM as well.

Project HOPE staff have been trained in the WHO standard M&E tools, which address SM issues at all level of the health care system and the quality of service delivery[26]. Project HOPE and OHD staff will implement these tools with the overall purpose of detecting/identifying problems and allowing the QAIWG to make decisions as to what needs to be adjusted in terms of training, service delivery, counseling, and supplies and equipment. The project will monitor a sample number of services using LQAS methodology to see how SM is being implemented and to

[26] The tools includes questionnaires, guides and observations list: 1. Antenatal Record Review; 2. Antenatal Client Exit Interview; 3. Normal Delivery Record Review (Partograph); 4. Complicated delivery (obstructed labour) record review (Partograph); 5. Complicated delivery (eclampsia or pre-eclampsia) record review; 6. Postpartum Care Observation; 7. Postpartum Client Exit Interview; 8. Family Planning Observation Guide; 9. Family Planning Client Exit Interview; 10. STI Patient Consultation Observation; 11. Exit Interview for STI Patients; 12. Interview with OB/GYN or midwife; 13. Facility Management; 14. Checklist for Instruments, Gloves and Equipment Processing. WHO/Safe Motherhood Program.

feed this information into OHD and the QAI WG. It should be pointed out, however, that the project team will not apply all WHO tools at once but will design and simplify them to be manageable in terms of resources and time. The decision as to what tools to be used will be an exercise the team will carry out on an ongoing basis.

At the community and Makhallah level, the project will use a combination of tools and methodologies to provide a complete understanding of the knowledge and practices of the community, leaders and other social actors, such as religious leaders, grandmothers, etc., involved in health education and social mobilization. Tools include: (a) close-ended questionnaires to be applied at the household level during LQAS assessments that are based on the KPC 2000 indicators; and (b) rapid assessment procedures (focus groups, key informant interviews and in-depth-interviews) about knowledge and practices of the population regarding SM knowledge and practices. These exercises will be applied in the following manner: (a) during LQAS sessions and on an as-needed basis, (b) when identifying and detecting problems in health education, and (c) when incorporating key messages into IEC dissemination and community participation. The external consultant contracted to help design the mahkallah-based strategy will also help select appropriate indicators for LQAS monitoring and for rapid appraisal procedures (RAP).

iv. Family Planning (30%)

Objectives: (1) Increase the number of women/couples with a birth interval at least 24 months after the previous surviving child; (2) Increase the number of women/adolescent/couples' knowledge of the reproductive cycle; (3) Increase the number of non-pregnant women who desire no more children or space births and are using a modern method of FP; and (4) Increase the number of family planning clients who received counseling on contraceptive choices, common side effects, and when to return for follow-up.

Main activities: The project will: (1) aim to improve the access and quality of family planning services in the target Rayons; (2) emphasize sexual education; (3) ensure that health facility health workers provide quality services; (4) develop adolescent-friendly health services strategy: (5) support and adapt new initiatives to improve quality, access and coverage of FP services; and (6) strengthen M&E systems for quality improvement.

Training Curricula and training plan: The first activity the project will carry out is TOTs and then training health staff in family planning. Curricula have been chosen from various sources – including Engender Health, JHPIEGO, and Zdrav Plus[27]. The

[27] 1. Guideline on counseling of the Family Planning patient, Uzbek version, Project HOPE, 2003.
2. A Manual for Trainers on RH, Russian version, 1996, AVSC International.
3. The Essentials of Contraceptive Technology: A Handbook for Clinical Staff. R. Hatcher, W. Reinehart, R. Blackburn, and J. Geller. JohnsHopkins Population Information Program. July 1997
4. A Manual on RH, Uzbek version, 2002, JPHEIGO.
5. Album "Family Planning", Engender Health, Uzbek version, 2002.

priority topics will include:

- General counseling so that users can make choices based on appropriate and correct information regarding all of the available methods, and then given additional information on the use of the method chosen.
- Provision of contraceptive methods (oral contraceptives, injectables, condoms, spermicide, surgical sterilization, and natural methods such as Lactational Amenorrhea Method (LAM) and the Standard Days Method) at the community level, including counseling, method delivery, and follow-up.
- Contraceptive counseling and informed consent, screening tests, counseling on natural methods (LAM and Standard Days Method), and for some health services, IUD insertion[28] (including training on mechanisms of action, insertion and removal techniques, infection prevention, prescription of prophylactic antibiotics, problem resolution, and follow up) at the clinical level.
- Management of secondary effects.
- Health information system and information management.

The first training activity will be to develop 20 trainers from the central rayon hospitals. Following this, the project will carry out two levels of FP and counseling training, a 5-day course for Ob/Gyns and GP staff, followed by a 3-day course for patronage nurses, totaling 107 Ob/Gyn, GPs and midwives from all levels of the health system. Finally, 475 patronage nurses and feldshers of SUBs, SVPs, SVAs and FAPs (120 in old rayons and 343 in new rayons) will be trained. The project will develop a four-year training plan to reach the proposed number of staff (see work plan). Training sites are the Reproductive Health Center in Navoi City, which has all the necessary equipment (slide projector and slides, pelvic models, etc.), and training rooms at the Rayon levels.

The project is also exploring the possibility of continuing surgical contraception (minilap) training for health providers. This will defined with the OHD during the first year of the project.

BCC and Makhallah/Community-based work focused on WRA and their partners: The project will initiate sessions under the new community strategy to orient Makhallah committees and leaders in reproductive health and family planning. The purpose of involving communities is to diversify and extend sexual education and reproductive health to more people in the community by providing direct messages to the general population. The project also needs to identify the traditional means of communicating used in the community in order to reach men and youth as well as women. In addition, the baseline showed a disproportionately high use of the IUD. The project will seek to determine whether the popularity of the IUD is due to provider bias, coercion, lack of availability/cost of other methods, or other possible

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6. Reproductive Health, ZdravPlus, Uzbek version, 2000.
7. Set of slides on conducting RH seminar, Engender Health, Russian version, 2001.
8. The Essentials of Contraceptive Technology: A Handbook for Clinical Staff. R. Hatcher, W. Reinehart, R. Blackburn, and J. Geller. Johns Hopkins Population Information Program. July 1997.

[28] The WHO Selective Recommendations for Provision of Contraceptives (published in 2001).

causes, including patient preference, before taking any action.

Adolescents Reproductive and Sexual Health (ARSH): In mid-2003, a yearlong ARSH project began with funds from Project HOPE Switzerland. The project had two main goals: (1) to increase adolescents' knowledge about sexuality and reproductive health and (2) to develop an adolescent-friendly health services strategy. USAID funds in this project will provide the basis to scale up and continue working with the adolescent population under the present project. Specifically, the project has updated a TOT manual and guide to train trainers[29] that will be used to train, in total, about 240 health providers GPs, midwives and patronage nurses as well as 240 school teachers. The work will be done mainly at the school level and at health facilities, but will not involve visits to adolescents' homes.

The school system in Navoi has a sexual education program for the adolescent population. Project HOPE has already developed and field-tested educational materials to strengthen the National "Healthy Family Planning" program at the school level. The project will carry out an evaluation of the school level materials developed in order to expand the activities and materials in other schools. In addition, Project HOPE's CS Project will train about 30 adolescents and train 2 teachers in each school, 160 peer educators, and will provide materials to supplement reproductive health material currently in the school libraries.

At the health facility level, Project HOPE will implement "Youth Friendly Services" in Navoi City and rayons as a pilot experience. In total, the project will train 240 health workers and will create one youth-friendly health "area" in each of the project rayons. The health providers' current training curriculum focuses on sexually transmitted diseases, but the project will add sexual education and boost provider skills for how to work with this vulnerable population. The project will adapt and use the "Focus on Young Adults, 2000" manual[30].

The project will develop and adapt IEC materials and an ARSH strategy with the participation of the OHD Adolescent Health Center, the BCCWG, local leaders and input from the adolescent population, and local NGOs working with youth in the communities.

BCC and Makhallah/Community-based work: Knowledge of reproductive health and sexuality was extremely low when interviewing adolescents in the baseline survey – only 3.9% of boys and 13.2% of girls knew that there are days in the menstrual cycle when women are more likely to get pregnant. In addition, only 1.3% reported that women are likely to get pregnant half-way between menstrual cycles. The baseline discussions with community leaders showed that girls are ignorant of the secondary changes in their growing bodies (breast development, menstruations, etc.) because their parents/elders do not usually explain them to the girls. As a result, there is great deal of fear and confusion

[29] TOT – "Adolescents Reproductive and Sexual Health"- a manual for trainers (Uzbek and Russian versions), Project Hope, Navoi 2003; and TOT – "Adolescents Reproductive and Sexual Health"- a guide for trainers (Uzbek and Russian versions), Project Hope, Navoi 2003.

[30] A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programs. Focus on Young Adults, Tool Series 5, June 2000

as to what is happening to them. Likewise, the baseline showed that while most adolescents had heard of HIV/AIDS, few had heard of other STIs. Perhaps this is due to the media attention given to HIV/AIDS. Lastly, the project will attempt to address the gender bias in the adolescent population towards "thinking it is important to be a virgin before marriage". Project HOPE's current work shows that girls tend to feel this is important while boys tend to feel that they need sexual experience before marriage.

Quality: Project HOPE will focus on improving the quality of FP service delivery through training, community education and close monitoring[31] and supervision. Complete information about the reproductive cycle, the full range of family planning methods and informed choice will be achieved through quality counseling at both the health facility and the community levels. In addition, the project will monitor the quality of the reproductive and sexual education activities at the school level and at the youth centers in Navoi City and selected health facilities.

The QAIWG, in close coordination with the Oblast and rayon statisticians and the MLWG will design, collect and analyze data from different sources (e.g., MOH health information system and LQAS and qualitative methods) in order to detect problems in the delivery of FP and sexual education, and to devise feasible and sustainable solutions. It has been observed that FP service delivery has been hindered by the lack and poor distribution of family planning methods; hence, the MLWG will be involved in the process. We view these working groups as interdependent, and they will fully coordinate and collaborate to provide the support required to improve the quality of service delivery.

As with the other interventions, the project will use a combination of instruments and tools[32] to assess the quality of activities at the community and school level. An important role will be given to community educators, such as grandmothers (including Mullah-bibis), who will be empowered with information on educating families and women about the woman's reproductive cycle, how to avoid unwanted pregnancies and how to plan family size and spacing between children. The project will then monitor the quality of the health messages and how education is transmitted to women, young girls, young boys, and families. Results of monitoring will be used to adjust or refine the health education messages, training or trainers and community-based strategies. The external consultant appointed to assist the team to develop the community-based strategies will also be requested to devise means of tracking quality indicators for decision making.

Although the ARH activities will be monitored as part of the overall monitoring component, it will have an additional component to assess reproductive health education at the school level and at the youth centers.

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[31] Follow-up and monitoring tools on RH/FP, AVSC International, 1996.

[32] Tools adapted have been selected from the following resources:
a. A Rapid Assessment of Youth Friendly Reproductive Health Services, Pathfinder International, Number 4, September 2003.
b. Clinic Asssessment of Youth Friendly Services. A Tool for Assessing and Improving Reproductive Health Services for Youth, Pathfinder International, 1997.

3. Program Monitoring and Evaluation Plan

The monitoring and evaluation plan is designed to register, analyze and make decisions regarding the actions implemented by Project HOPE and its main counterpart, the Navoi Health Department. The M&E plan will also aim to indicate performance and quality of service delivery and community-based work, and to provide criteria that guarantee that the goals and objectives have been met.

The M&E plan is based on a series of data sources and methodologies that are complementary and will provide information on different levels of the Navoi health system and community-based activities. Project HOPE will expand the function of the MCH steering committee to develop four multi-disciplinary taskforces or Technical Working Groups (TWG), which although independent, will fully coordinate and collaborate to provide an integrated view to guarantee the successes and institutionalization of project activities. These TWGs will triangulate and complement sources of information and involve health staff in data analysis and interpretation for decision making. As described in the Capacity Building section, the QAIWG will review the results of the M&E system, identify areas of weakness and will suggest and/or make project changes to respond to the identified needs.

Each project intervention has a particular M&E plan with different information needs, and each will use different M&E instruments and methodologies. Each specific "plan for achieving quality" is described in the Intervention Specific Approach Section. The overall plan for the M&E and its components are described below.

KPC Surveys. A 30-cluster cross sectional survey will be carried out at the beginning and at the end of the project. The survey will target mothers of children under 24 months of age, women of reproductive age, and adolescents (See the baseline survey report in the **Annex E**)

Health Facility Assessment. A baseline HFA using an approximately 50% sample of all facilities has been carried out externally in the original two rayons at the end of the previous project, and will be carried out in the two new rayons in 100% of facilities as part of the intervention Quality Improvement processes.

Mid-term Evaluation. Project HOPE will carry out a mid-term evaluation according to USAID/CSHGP guidelines. In addition, an external consultant will assess the training plan and M&E systems development, implementation and decision making and provide recommendations for the second half of Phase 2 of the project.

MOH Health Information and Supervision System: The project will continue using the MOH health information system to obtain information on basic demographic indicators, logistic systems and delivery of project interventions. The MOH health information system collects information from all levels of care specific to adult, maternal

and child health interventions. Information includes vital statistics by catchment areas (i.e., total population by gender and age, newborns, deaths and number of cases attended by health intervention or specialty.) The system also tracks information about the health system structure (i.e., health services by specialty, health personnel, and basic equipment and supplies, etc.) All of this information is then compiled at the rayon and oblast levels. Therefore, the project will support and strengthen the system by facilitating analysis of data and decision making. Some project indicators can only be obtained from the MOH health information system, such us couple of years of protection (CYP) and new users of FP.

At the primary health care level, there are also other sources of information that are utilized by health care workers such as patients' clinical records, information collected on home visits and during other community-based activities. This information will be used to assess quality of service delivery and quality improvement by means of record reviews and the assessment of patients' satisfaction with the services received.

Lot Quality Assurance Sampling (LQAS)[33&34]: In addition to the MOH health information system, Project HOPE will implement the LQAS methodology to assess the quality of service delivery, staff performance and the delivery of key messages.

The project will emphasize monitoring at the primary health care level, and the monitoring cycle will be every six months. The supervision/monitoring area to be chosen will be the population served by a SUB, SVP, SVA or FAP. A two-stage sampling design will be applied. The first stage will be to select three supervision/monitoring areas for each one of the four project rayons, totaling 12. The second stage will be to select 19 households from the selected supervision/monitoring areas, totaling 228. In addition, in each catchment area, the project will monitor activities in the local health facility, the Makhallah center and secondary schools where we are working in ARH.

Other components of the M&E plan include:

- **Household Interviews:** The project will interview 19 families in each supervision area. Questions will be selected from the KPC and Flex Funds questionnaires, plus other information the TWGs consider necessary. The household questionnaires will be short and will focus on only a few key health practices.

- **Health Facility:** At the health facility level, the project already has adapted and applied the standard WHO instruments for IMCI and SM for the final evaluation of the first phase of the project. For the second phase of the project, the QAIWG will streamline the number of instruments and their contents to create an efficient tool that can be applied easily using the LQAS methodology twice a year.

[33] Assessing Child Survival Programs in Developing Countries. Testing Lot Quality Assurance Sampling. J. Valadez, Ph.D., MPH, SD. Department of Population and health. Harvard SPH. Boston, MA. 12/1991.
[34] Assessing Community Health Programs. Using LQAS for baseline Surveys and Regular Monitoring. J. Valadez, W. Weiss, C. Leburg, and R. Davis. TALC. January 2003

It is important to note that the MOH Staff are required under the official *prikazes* to carry out monitoring of IMCI and SM according to WHO protocol. Thus this project is not creating a parallel monitoring system, but facilitating quality monitoring and supervision on the ground. The current MOH set of IMCI and SM monitoring instruments for the health facility are already translated into Russian and Uzbek.

- IMCI tools include: Exit Interview--Well Child; Sick Child Management Stages; Questionnaire for identification the situation in the hospital; Criteria: A child under age 5 with diarrhea; Criteria: A child under age 5 with fever; Criteria: A child under age 5 in lethargic stupor, unconsciousness or convulsions; Criteria: A child under age 5 with cough or difficult breathing; Criteria: A child without asthmoid breathing, stridor or chronic cough; Criteria: A child under Age 5 with cough or difficult breathing/kids with asthmoid breathing; Criteria: A child under age 5 with cough or difficult breathing/kids with chronic cough; Criteria: A child under age 5 with cough or difficult breathing/kids with stridor; Questionnaire For Parents – sick child; Observation Checklist – Sick Child; Interview with Chief Doctor; Equipment and Supplies Checklist; Interview with Health Worker.

- Safe Motherhood tools include: Antenatal Record Review; Antenatal Client Exit Interview; Normal Delivery Record Review (Partograph); Complicated delivery (obstructed labour) record review (Partograph); Complicated delivery (eclampsia or pre-eclampsia) record review; Postpartum Care Observation; Postpartum Client Exit Interview; Family Planning Observation Guide; Family Planning Client Exit Interview; STI Patient Consultation Observation; Exit Interview for STI Patients; Interview with OB/GYN or midwife; Facility Management; and Checklist for Instruments, Gloves and Equipment Processing.

The Uzbek MOH has not yet developed sets of health facility level M&E instruments for FP and Breastfeeding. Thus, the project will adapt and field test instruments for this level based on international standards.

- **Makhallah Centers and Schools:** Finally, as part of the LQAS semiannual exercise, the project will also visit the supervisor area Makhallah Center and a secondary school to assess community participation and adolescent reproductive and sexual health education activities.

Quality Improvement. Quality Improvement (QI) is a dynamic process involving facility staff in assessing and improving services and dealing with system problems. Carried out in "cooperatives" of multiple facilities all initiating similar improvements, it is a powerful tool to bring about both improvements in quality of existing processes and initiation of new processes and also to encourage and motivate participating facilities and personnel to take responsibility and move forward. HOPE will provide experienced Technical Assistance and training to upgrade the technical capacities of key officers in order to introduce the QI and cooperative methods and to stimulate a culture of critical

thinking and problem solving action within the available resources. Information results will be shared with the *Health Family* Project in Tashkent and Project HOPE's home office on a semiannual basis. The project will also use this opportunity to share information at the national level and with other agencies working in health. Project HOPE will also take action to increase information sharing, feedback and communication between communities/Makhallah administration and health facilities.

An external consultant will be contracted to train the working group members and facility staff on the QI process and skills including data analysis as part of the QI action steps. M&E results and lessons learned will feed into these efforts. The QI effort will include improving the effectiveness of supervision and monitoring.

Operations Research. In Phase 1, four separate operations research studies were carried out[35]. During this period, Project HOPE staff and counterpart OHD and rayon health providers were trained in how to conduct operational research. These studies were the basis of the behavior change communication strategy that has evolved into a more integrated makhalla-based Community health strategy.

Project HOPE will carry out two operations research activities during the life of Phase 2 of the project. The first one is a follow-on project of the in-depth diagnostic study of "The Role of Grandmothers and Other Household Actors in Maternal and Child Health," carried out by Judi Aubel and the Navoi team. In this study, it was shown that paternal grandmothers' influence on maternal and child health practices in the home is perhaps more influential than either a mother of small children (daughter-in-law), her husband, or even the paternal grandfather. The study also showed the influences of female makhalla committee leaders and of men both at the makhalla committee level and in the homes. During the follow-on activity a makhalla-based strategy will be developed based on recommendations of the study. Project HOPE, with community stakeholder partners, will identify clear objectives and then set specific targets that will be tracked through a simple and coherent information collection system. The intervention will be applied in a small area. Based on the results and lessons learned, the project will scale up the intervention to all project areas.

Project HOPE and their counterparts will conduct a second operations research involving men in maternal, child and reproductive health. A few of the operations research studies conducted previously took into account men, but additional data is needed to determine the role of men in the key project interventions. The analysis of this research will be incorporated into the Makhalla-based Community health strategy, to be carried out after the second year of the project.

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[35] a. "Postpartum services assessment for new/first mothers in Navoi Oblast", Uzbekistan-August, 2000. Stella Aslanyan-intern, Nigora Muratova-maternal health specialist; b. "C-IMCI Formative Research"- January, 2002. Pediatrician Research Institute, Project HOPE staff.; c. "New Father Research at Baby Friendly Hospitals". Gal Frenkel-intern; and d. "The Role of Grandmothers and Other Household Actors in Maternal and Child Health" - July, 2003. Judi Aubel.

Rapid Assessment Procedures (RAP). Finally, the project will also apply qualitative methodologies, such as focus group discussions, to explore further: (1) client satisfaction, (2) the population's perception of the quality of services received, (3) barriers to health interventions, and (4) the design of better community participation and mobilization activities. Project HOPE staff members were trained in RAP by an external consultant before they conducted operations research for grandmothers last year. RAP will be carried out on a per need basis.

a. Table of Monitoring and Evaluation Indicators

The following table summarizes the main indicators the project will use through the different methodologies and time frames. Only the baseline and FE Evaluation indicators will remain strictly unchanged, while the monitoring indicators are illustrative of the information the project will obtain on an ongoing basis. The team may decide to add, remove or refine some of monitoring indicators according to project needs and the MOH's health policy. For instance, staff might find they wish to track more closely key adolescent practices regarding sexual education and STIs, and thus they might develop additional indicators relevant to obtaining this information.

a. INTERVENTION: IMCI (30%): ARI/PNEUMONIA CONTROL (10%); CONTROL OF DIARRHEAL DISEASES (10%); AND CHILD NUTRITION (10%)

Indicators: Definitions and units of measurement	Data source and collection method	Frequency of data collection	Baseline 2004	Targets 2007
Desired Result: *Adopt/Strengthen an integrated approach for improving child health* ***Objectives:*** *1. Increase the proportion of mothers recognizing fast breathing and chest indrawing as signs of pneumonia;* *2. Increase the proportion of children with signs of pneumonia who were assisted by a trained health provider;* *3. Increase the ORT use rate;* *4. Increase the percentage of mothers who recognize danger and dehydration signs;* *5. Increase the percentage of mothers who give the child more/equal amounts of liquids during diarrhea;* *6. Increase from the proportion of mothers who continued feeding the child during a diarrhea episode;* *7. Increase the proportion of mothers who introduce solid and semisolid foods to children between 6-9 months of age, and by means of frequency and quality of weaning foods.* *8. Increase the percentage of children aged 20-23 months still breastfeeding* *9. Increase appropriate complementary feeding practices after six months of age; i.e., quantity and quality of foods, breastfeeding first then foods, and introduction of micronutrients (Fe, iodine and Vitamin A)*				
Percent of mothers of children aged 0-23 months who know at least TWO signs of childhood illness that indicate the need for treatment	KPC 2000+	Baseline Survey (BL), Midterm (MT), and Final Evaluation (BL)	48.6%	68%
Percent of infants aged 6-9 months who received breastmilk and solid foods in the last 24 hours	KPC 2000+	BL, MT, FE	33.9%	45%
Percent of children aged 20-23 months who are still breastfeeding	KPC 2000+	BL, MT, FE	33.0%	45%
Percent of mothers who know at least TWO signs childhood diarrhea that indicate the need for treatment/referral	KPC 2000+	BL, MT, FE	36.9%	58%
Percent of children aged 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids	KPC 2000+	BL, MT, FE	31.8%	60%
Percent of children aged 0-23 months with diarrhea in the last two weeks who were offered more fluids during the illness	KPC 2000+	BL, MT, FE	15.0%	40%
Percent of children aged 0-23 months with diarrhea in the last two weeks who were offered the same amount or more food during the illness	KPC 2000+	BL, MT, FE	19.0%	30%

Indicators: Definitions and units of measurement	Data source and collection method	Frequency of data collection	Baseline 2004	Targets 2007
Percent and total number of children aged 0-23 months with cough and fast/difficult breathing in the last two weeks who were taken to a health facility or received antibiotics from an alternative source	KPC 2000+	BL, MT, FE	88.1%	90%
Percent of children who were examined for 4 common danger signs	HF- Case management observation	Semiannual		
Percent of children who were examined on cough, diarrhea and fever signs	HF- Case management observation	Semiannual		
Percent of mothers of children 0-23 months of age, who were asked and explain proper breastfeeding and complementary feeding practices	HF- Case management observation	Semiannual		
Percent of children in need of medication, who received the necessary medication according to disease classification	HF- Case management observation	Semiannual		
Percent of mothers/caretakers who can repeat health providers' recommended treatment/management	HF- Exit interview	Semiannual		
Percent of Primary Health Care facilities (Polyclinic, SUB, SVP, SVA and FAP) that carry out IMCI interventions	HF-management	Semiannual		
Percent of health services that have standard IMCI case management protocols	HF- Case management observation	Semiannual		
Percent of health services that have essential drugs and medicines for to deliver IMCI services	HF-equipment and supplies list	Semiannual		
Percent of health services that have IEC-counseling materials on IMCI	HF-equipment and supplies list	Semiannual		
Percent of health services that have essential equipment and supplies for IMCI	HF-equipment and supplies list	Semiannual		

INTERVENTION: BREASTFEEDING PROMOTION (10%)

Indicators: Definitions and units of measurement	Data source and collection method	Frequency of data collection	Baseline 2004	Targets 2007
Desired Result: *Adopt/Strengthen appropriate feeding practices for improving child nutrition and growth* ***Objectives:*** *1. Increase the percentage of mothers exclusively breastfeeding their infant for the first six months;* *2. Increase the percent of children receiving BF during the first hour of birth;* *3. Increase the percent of newborns that were put skin-to-skin contact with mother immediately after birth, and for at least 30 minutes.*				
Percent of children aged 0-23 months who were breastfed within the first hour after birth	KPC 2000+	BL, MT, FE	62.6%	85%
Percent of infants aged 0-5 months who were fed breastmilk only in the last 24 hours	KPC 2000+	BL, MT, FE	62.7%	85%
Number of health facilities currently certified under the National participation in the Baby-Friendly Hospital Initiative (BFHI).	Project HOPE HIS, UNICEF & MOH	BL, MT, FE	3	5
Breastfeeding counseling during pregnancy, prior to discharge from maternity, and during post-partum visits	HF-Exit interviews	Semi-annual		
Skin-to-skin contact for at least 30 minutes in the first hour after delivery	HF-Exit interviews after discharge	Semi-annual		
Rooming-in rate	HF-Exit interviews after discharge	Semi-annual		
Existence of written clinical service delivery protocols for breastfeeding women	HF-Health facility check list	Semi-annual		
Percent of mothers with infants under six months of age who are supported or advise by a member of their community (mother support group leaders, Makhallah Educators or close relative/grandmother) how to exclusively breastfeed: frequency, positioning, avoid bottles, and breastfeeding on demand	Focus Group Discussions	Semi-annual		
Percent of health services that have IEC-counseling materials on Breastfeeding	HF-equipment and supplies list	Semiannual		

INTERVENTION: SAFE MOTHERHOOD/NEWBORN CARE (30%)

Indicators: Definitions and units of measurement	Data source and collection method	Frequency of data collection	Baseline 2004	Targets 2007
Desired Result: *Adopt/Strengthen integrated approach for improving perinatal care* ***Objectives:*** *1. Increase the number of mothers who received/buy iron supplements while pregnant; 2. Percent of mothers who had at least one postpartum check-up; and 3. Percent of mothers who know the danger during pregnancy, delivery and postpartum that indicate the need for treatment.*				
Percent of mothers who had at least one prenatal visit prior to the birth of her youngest child less than 24 months of age	KPC 2000+	BL, MT, FE	99.8	100%
Percent of mothers who received/bought iron supplements while pregnant with the youngest child less than 24 months of age	KPC 2000+	BL, MT, FE	54.1%	70%
Percent of mothers who know at least TWO signs of danger during pregnancy that indicate the need for treatment	KPC 2000+	BL, MT, FE	46.9%	70%
Percent of mothers who had at least one postpartum check-up	KPC 2000+	BL, MT, FE	76.9%	92%
Percent of deliveries that use partograph to manage labor by type of health worker/health facility	HF-records review	Semiannual		
Percent of Primary Health Care facilities (Polyclinic, SUB, SVP, SVA and FAP) that carry out Safe Motherhood interventions (needs further operational definition to determine SM service delivery).	HF-management	Semiannual		
Percent of health services that have Safe Motherhood standard management protocols	HF-case management observations	Semiannual		
Percent of health services that have essential drugs and medicines for to provide Safe Motherhood services	HF- equipment and supplies list	Semiannual		
Percent of health services that have IEC-counseling materials on Safe Motherhood	HF- equipment and supplies list	Semiannual		

INTERVENTION: FAMILY PLANNING (30%)

Indicators: Definitions and units of measurement	Data source and collection method	Frequency of data collection	Baseline 2004	Targets 2007
Desired Result: *Adopt/Strengthen informed choices so couples and families will have the number of children they want whenever they want* ***Objectives:*** *1. Increase the number of women/couples with a birth interval at least 24 months after the previous surviving child; 2. Increase the number of women/couples' knowledge of the reproductive cycle; 3. Increase the number of non-pregnant women who desire no more children or space births, who are using a modern method of FP; and 4. Increase the number of family planning clients who have receive counseling on contraceptive choices, common side effects, and when to return for follow-up.*				
Adequate Birth Interval Between Youngest Surviving Children: Percent of children aged 0-23 months who were born at least 24 months after the previous surviving child	KPC 2000+	BL, MT, FE	48.3%	68%
Percent of women of RA who report that women are likely to get pregnant halfway between two menstrual periods	KPC 2000+	BL, MT, FE	9.3%	45%
Percent of non-pregnant women who desire no more children in the next two years, or are not sure, who are using a modern method of child spacing	KPC 2000+	BL, MT, FE	72.6	85%
Percentage of respondents who report discussing FP issues with somebody in the past 12 months	KPC 2000+	BL, MT, FE	56.2	75%
Counseling: Percentage of family planning clients who receive counseling on contraceptive choices, common side effects, and when to return for follow-up	KPC 2000+	BL, MT, FE	62.7	78%
Couple-years of protection (CYP)	MOH's HIS	Monthly		
Number of acceptors new to modern contraception	MOH's HIS	Monthly		
Percent of Primary Health Care facilities (Polyclinic, SUB, SVP, SVA and FAP) that carry out Family Planning standard management protocols	HF-management	Semiannual		
Percent of health services that have Family Planning standard management protocols	HF- equipment and supplies list	Semiannual		
Percent of health services that have all methods (non-surgical) to deliver FP services	HF- equipment and supplies list	Semiannual		
Percent of health services that have IEC-counseling materials on Family Planning	HF- equipment and supplies list	Semiannual		

Indicators: Definitions and units of measurement	Data source and collection method	Frequency of data collection	Baseline 2004	Targets 2007
Percent of health services that have essential equipment and supplies for Family Planning	HF- equipment and supplies list	Semiannual		
Percent of adolescent population (15-18) who know that women are likely to get pregnant halfway between two menstrual periods	FlexFunds Questionnaire	BL, MT, FE	1.3%	40%
% of adolescents who can name at 2 or more methods of protecting oneself against contracting STIs	KPC 2000+	BL, MT, FE	16.7%	50%
% of adolescents can name 2 or more mechanisms of HIV transmission.	KPC 2000+	BL, MT, FE	44.2%	75%
% of adolescents who can name at least 3 signs of STIs in men	KPC 2000+	BL, MT, FE	0.5%	40%
% of adolescents who can name at least 3 signs of STIs in women	KPC 2000+	BL, MT, FE	0.5%	40%
% of adolescents who can name at least three methods of birth spacing methods	KPC 2000+	BL, MT, FE	29.8%	70%
Established # of (health facility based) Adolescent-Friendly RH services in Navoi Oblast	Project HOPE HIS	Annual	0	1 Navoi 4 pilot rayons

4. Work Plan by Major Activities

Activity Focus Legend: A = Access, BC= Behavior Change, and Q= Quality

Integrated Management of Childhood Illnesses (IMCI) (30%): ARI/Pneumonia control (10%); Control of Diarrheal Diseases (10%); and Child nutrition (10%)

Major Activities	Activity Focus	Year 1 10/2003 – 9/2004				Year 2 10/2004 – 9/2005				Personnel Responsible	Output/ Outcome of Activity Desired
		1	2	3	4	1	2	3	4		
Oblast Level ***(Coordination with Stakeholders (Inter-Institutional Steering Committee, Oblast/MOH, local NGOs, community groups)***											
Steering Committees											
Orientation meeting on IMCI & BF in rayon level	A			X						OHD, IMCI Center & Project HOPE	2 (In Konimeh and Nurata rayons)
Health Facility Level											
Printing of IMCI guidelines	A,BC,Q			X						Project HOPE	120 participants set (there are 8 books in set) 20 trainers set (there are 3 books)
11 days IMCI training	A,Q			X	X	X				OHD, IMCI Center & Project HOPE	Will be trained 54 GPs, Pediatricians (3 courses)
5 days IMCI TOT	Q			X						OHD, IMCI Center & Project HOPE	Will be trained 18 GPs, Pediatricians trained on 11 days IMCI
3 days Refresher course on IMCI	A,Q			X	X		X		X	OHD, IMCI Center, Project HOPE	Will be conducted 5 refresher course for 100 previous trained HP
5 days IMCI monitoring course	Q			X						OHD, IMCI Center & Project HOPE	Will be trained 18 GPs, Pediatricians which trained on 11 days IMCI (may be 5 days TOT too).
Monitoring of trained HP	Q			X	X	X		X		OHD, IMCI Center & Project HOPE	1 monitoring and to hand certificate will be after 1 month after training if performs over 85%. Other monitoring will be 6 months after previous monitoring using LQAS sampling methodology.
Community Level											
Translation, adaptation, and printing of C-IMCI guidelines.	A,Q				X	X				OHD, IMCI Center, Project HOPE, Health Institute Branch, Community representatives	400 C-IMCI guidelines will be printed
1 day TOT/orientation for IMCI trainers	Q						X			OHD, IMCI Center & Project HOPE	Will be trained/orientated 20 IMCI trainers on C-IMCI TOT

Major Activities	Activity Focus	Year 1 10/2003 – 9/2004				Year 2 10/2004 – 9/2005				Personnel Responsible	Output/ Outcome of Activity Desired
		1	2	3	4	1	2	3	4		
6 days C-IMCI,BF,RH,SM training for nurses	A,Q						X	X	X	OHD, IMCI Center & Project HOPE	Will be trained 260 patronage nurses
1 days refresher course on C-IMCI	A,Q			X		X	X	X	X	OHD, IMCI Center & Project HOPE	Will be conducted 16 refresher course on C-IMCI for 320 previous trained HP
Monitoring on C-IMCI	Q						X	X	X	OHD, IMCI Center, Project HOPE, Health Institute Branch	530 trained HP will me monitored
Evaluation of booklet on C-IMCI and posters	Q				X	X				OHD, IMCI Center & Project HOPE, Health Institute Staff, Community representatives	Will be evaluated 2 posters and booklet developed by Project HOPE
Printing of C-IMCI booklet and posters	A					X				Project HOPE	Posters 1000 Booklets 45000
Orientation meeting for Community on C-IMCI and BF	BC						X			Oblast/rayon administration, OHD, IMCI Center, Health Institute Branch & Project HOPE	2 (In Nurata and Konimeh)
1 day orientation/training for Makhallahs' leaders on C-IMCI and BF	BC						X			Rayon administration, OHD, Health Institute Branch & Project HOPE	Will be trained 240 makhalla leaders.
Dissemination of C-IMCI booklet and posters	A,BC						X	X		OHD, Health Institute Branch, Community representatives & Project HOPE	1000 45000
Community mobilization activities on C-IMCI	BC						X	X	X	Oblast/Rayon administration OHD, IMCI Center, Health Institute Branch & Project HOPE , Mahalla leaders	Will be conducted various activities in community: meeting/discussion with child care takers, grandmothers; competitions, TV & Radio broadcasts, etc.

Safe Motherhood/Newborn Care (30%)

Major Activities	Activity Focus	Year 1 10/2003 – 9/2004				Year 2 10/2004 – 9/2005				Personnel Responsible	Output/ Outcome of Activity Desired
		1	2	3	4	1	2	3	4		
Oblast Level ***(Coordination with Stakeholders (Inter-Institutional Steering Committee, Oblast/MOH, local NGOs, community groups)***											
Steering Committees											
Orientation meeting in Rayon level on SM/RH/ARH	A,Q					X				OHD, SM Center & Project HOPE	2 (Konimeh, Nurata)
Health Facility Level											
Printing of SM materials	A, BC					X				Project HOPE	9 days – 200 set (3 books in each set) 5 days – 540 set (2 books in each set) 6 days – 500 set for participants (2 books in each set) 30 set for trainers (3 books in each set)
3 days TOT course	BC,Q					X				OHD, SM Center & Project HOPE	Will be trained 18 (1 course) OB/GYNs, Neonatologest, Midwifes and neonatal nurses which already trained on SM course
9 days training courses on Essential perinatal, labor and postnatal care	BC,Q					X	X	X	X	OHD, SM Center & Project HOPE	Will be trained 90 (5 courses) OB/GYNs, Midwifes
2 days refresher course on SM/PEPC for OB/GYNs	A,Q				X		X		X	OHD, SM Center & Project HOPE	Will be conducted 3 refresher courses on SM/PEPC for 60 previous trained HP
5 days training on Essential newborn care	BC,Q					X				OHD, SM Center & Project HOPE	Will be trained 18 (1 course) Neonatologest, neonatal nurses
1 days refresher course on SM/PEPC for Neonotologest	A,Q					X			X	OHD, SM Center & Project HOPE	Will be conducted 2 refresher course for 40 previous trained HP
5 days TOT training on Essential perinatal, normal deliveries and postnatal care for PHC	BC,Q					X				OHD, SM Center & Project HOPE	Will be trained 18 trainers on Essential perinatal, normal deliveries and postnatal care for PHC
6 days training on Essential perinatal, normal deliveries and postnatal care for PHC	BC,Q					X	X	X	X	OHD, SM Center & Project HOPE	Will be trained 216 (12 course) GPs, faldshers, PHC OB/GYN, midwifs

Major Activities	Activity Focus	Year 1 10/2003 – 9/2004				Year 2 10/2004 – 9/2005				Personnel Responsible	Output/ Outcome of Activity Desired
		1	2	3	4	1	2	3	4		
Adaptation and translation of monitoring tools	Q			X	X					OHD, SM Center & Project HOPE	WHO SM monitoring tools in Russian and English will be translated and adapted.
5 DAYS Training on Follow-up & monitoring	BC,Q						X			OHD, SM Center & Project HOPE	Will be trained 20 (1 course) OB/GYNs, Neonatologist, Midwives and neonatal nurses which already trained on SM course (may be SM TOT too)
Follow-up & monitoring	Q				X	X	X	X	X	OHD, SM Center & Project HOPE	660 trained HPwill be monitored
Establish Safe Motherhood Center in Oblast Maternity House	A,Q			X						Oblast administration, OHD & Project HOPE	1 Training Center will be created in Oblast Maternity house
3 days study tour in Andijan Maternity House	A,Q							X		OHD, SM Center & Project HOPE	12 key specialist trained on SM will visit to Andijan to see they experience on SM
Neonatal Resuscitation	A,Q						X			OHD & Project HOPE	20 Neonatologists trained
Community Level											
Develop IEC materials for community	A,BC						X	X		OHD, SM Center, Health Institute Branch, Project HOPE, Community representatives	Booklet-35000 Posters-1000
Printing of IEC materials	A,BC								X	Project HOPE	Booklet-35000 Posters 1000
Dissemination of IEC materials	A,BC								X	OHD, SM Center, Health Institute Branch, Project HOPE, Community representatives	Booklet-35000 Posters-1000
Community mobilization activities on SM	A,BC								X	OHD, SM Center, Health Institute Branch, Community representatives & Project HOPE	Will be conducted various activities in community: meeting/discussion with woman RH age, grandmothers; competitions, TV & Radio broadcast…

Breastfeeding (10%)

Major Activities	Activity Focus	Year 1 10/2003 – 9/2004				Year 2 10/2004 – 9/2005				Personnel Responsible	Output/ Outcome of Activity Desired
		1	2	3	4	1	2	3	4		
Oblast Level ***(Coordination with Stakeholders (Inter-Institutional Steering Committee, Oblast/MOH, local NGOs, community groups)***											
Steering Committees											
Orientation meeting in Rayon level on BF/IMCI	BC,Q			X						OHD & Project HOPE	2 (Konimeh, Nurota)
Health Facility Level											
Translation of BF TOT and Participation guide into Uzbek. Printing.	Q			X						OHD & Project HOPE	For TOT – 25 Fop participants- 450
(5 days) 40 hours training	BC,Q			X						OHD, SM Center & Project HOPE	Will be trained 20 (1 course) OB/GYNs, Midwives, Neonatologist, neonatal nurses
3 days TOT course	A,BC,Q			X						OHD, SM Center & Project HOPE	Will be trained 20 (1 course) OB/GYNs, Midwifes, Neonatologist, neonatal nurses that already trained on 5 days BF course.
18 hours BF training	BC,Q			X	X	X	X	X	X	OHD, SM Center & Project HOPE	Will be trained 280 (14 course) GPs, feldshers, HP
1 days refresher course on BF	A,BC			X		X		X		OHD, SM Center & Project HOPE	Will be conducted 4 refresher course on BF for 80 previous trained HP
Developing training manual, tools for monitoring	Q			X						OHD, SM Center & Project HOPE	To develop training manual, tools for monitoring PHC HP trained on BF
Training on Follow-up & monitoring	BC,Q				X					OHD, SM Center & Project HOPE	Will be trained 20 (1 course) OB/GYNs, Midwives, Neonatologist, neonatal nurses which already trained on BF course
Follow-up & monitoring	Q			X	X	X	X	X	X	OHD, SM Center & Project HOPE	540 HP will be monitored
Develop BF support group counselors	A,BC,Q			X	X	X	X			OHD, SM Center, Community representatives, Project HOPE	276 BF support group counselors
Monitoring of Baby-friendly clinics	Q					X			X	OHD, SM Center, Project HOPE, Institute of pediatrician	10 monitoring will be conducted
Certification of Baby-friendly clinics	A,Q						X			OHD, SM Center, Project HOPE, Institute of pediatrician	2 certification will be conducted

Major Activities	Activity Focus	Year 1 10/2003 – 9/2004				Year 2 10/2004 – 9/2005				Personnel Responsible	Output/ Outcome of Activity Desired
		1	2	3	4	1	2	3	4		
Recertification	Q			X		X				OHD, SM Center, Project HOPE, Institute of pediatrician	3 Recertification will be conducted
Community Level											
Develop and adopt existing IEC materials.	A,BC						X	X		OHD, SM Center, Project HOPE, Health Institute branch, Community representatives	Will be revived existing IEC materials and developed pamphlet, poster
Printing IEC materials	A,Q								X	Project HOPE	35000-booklets 1000-poster
Dissemination of IEC materials	A,BC								X	OHD, SM Center, Health Institute Branch, Project HOPE, Community representatives, BF support group.	35000-booklets and 1000 posters will be disseminated to woman who breastfeed
Community mobilization activities on BF	A,BC,Q			X	X	X	X	X	X	OHD, Health Institute Branch, Community representatives & Project HOPE, BF support group.	Will be conducted various activities in community: meeting/discussion with woman RH age, grandmothers; competitions, TV & Radio broadcast, BF week in august each year.

Family Planning (30%)

Major Activities	Activity Focus	Year 1 10/2003 – 9/2004				Year 2 10/2004 – 9/2005				Personnel Responsible	Output/ Outcome of Activity Desired
		1	2	3	4	1	2	3	4		
Oblast Level ***(Coordination with Stakeholders (Inter-Institutional Steering Committee, Oblast/MOH, local NGOs, community groups)***											
Orientation meeting in Rayon level on SM/RH/ARH	A,BC					X				OHD, RH Center & Project HOPE	2 (Konimeh,Nurota)
Establish adolescent-friendly RH services at Adolescents polyclinic	A			X				X		OHD & Project HOPE	5 adolescents friendly RH services will be established
Develop checklists and monitor adolescent RH services	Q									OHD, RH and ARH Centers, Project HOPE, teachers	Will be developed the tools for monitoring of HP trained on ARH and 140 HP trained ARH will be monitored
Health Facility Level											
3 days TOT course	A,BC,Q					X				OHD & Project HOPE	For 20 (1 course) OB/GYNs, midwifes
Printing of training materials on RH	A, BC				X					Project HOPE	3 days -800 books 5 days – 100 books
5-days training on RH and counseling	BC,Q				X	X	X	X	X	OHD, ARH, & Project HOPE	For 100 (5 course) GPs, OB/GYNs, PHC midwifes
3-days training on FP and counseling	BC,Q				X	X	X	X	X	OHD, RH Center, & Project HOPE	For 380 (19 course) patronage nurses, feldshers, maternity house's midwives
1 day refresher course on FP and RH	A,Q				X		X		X	OHD, RH Center, & Project HOPE	Will be conducted 3 refresher courses on RH for 60 previous trained HP
5 days training on Follow-up & monitoring	A,BC,Q				X					OHD, RH Center & Project HOPE	For 20 (1 course) HP trained on 5-3 days RH courses
Follow-up & monitoring	Q				X	X	X	X	X	OHD, RH Center & Project HOPE	480 HP will be monitored
5 days training on minilap	A							X		OHD, RH Center & Project HOPE	For 20 (1 course) OB/GYN
5 days training ARH TOTs	A,BC,Q					X				OHD, ARH Center & Project HOPE	For 20 (1 course) OB/GYNs, Adolescents HP

Major Activities	Activity Focus	Year 1 10/2003 – 9/2004				Year 2 10/2004 – 9/2005				Personnel Responsible	Output/ Outcome of Activity Desired
		1	2	3	4	1	2	3	4		
Testing, printing of educational materials for ARH providers	BC			X						OHD, ARH Center & Project HOPE	Developed ARH training materials will be tested in Navoi city and in September, 2004 will be printed: Manual for trainers-270; reference manual-270; Manual for participants - 4760
5 days training school health providers and teachers in adolescent RH services	BC,Q				X	X	X	X	X	OHD, ARH Center & Project HOPE	For 240 (12 course) HP & teachers
Developing monitoring training plan and tools	Q									OHD, ARH Center & Project HOPE	Will be developed monitoring tools and monitoring training plan on ARH.
5 days training on follow-up visits and monitoring	BC,Q					X				OHD, ARH Center & Project HOPE	For 20 (1 course)HP and teachers which trained ARH cours
Conduct follow-up visits and monitoring	BC,Q			X		X		X		OHD, ARH Center & Project HOPE	120 Adolescents HP will be monitored
Community Level											
Orient Makhallah committees on RH & FP/SM/ARH	A,Q								X	Oblast/Rayon Administration, OHD & Project HOPE, Health Institute Branch, Community leaders	4 (Kiziltepa, Navoi, Konimeh, Nurota)
Printing RH IEC materials	A,Q					X				Project HOPE	Pamphlets 50000 Posters 1000
Adapt/develop adolescent RH educational materials (booklets, posters)	A,Q		X		X					OHD, ARH Center & Project HOPE, Health Institute, Adolescents leaders,	Booklet 50000 Posters-1000
Pilot testing of PtoP materials	Q	X	X							OHD, ARH Center & Project HOPE	180 books will be printed
Identify peer trainers and conduct 4 days TOT for them	A					X	X	X	X	OHD, ARH Center & Project HOPE, Oblast Educational Department	For 160 adolescents
Conduct of posters competition in target area	A,BC			X				X		OHD, ARH Center & Project HOPE, Oblast Educational Department, Health Institute branch	In each year will be conducted pister competition in each rayons then in oblast level

Major Activities	Activity Focus	Year 1 10/2003 – 9/2004				Year 2 10/2004 – 9/2005				Personnel Responsible	Output/ Outcome of Activity Desired
		1	2	3	4	1	2	3	4		
Conduct 2 days training events for adolescents;	A				X	X	X	X	X	OHD, ARH Center & Project HOPE, Oblast Educational Department	For 1020 adolescents
Developing ARH booklets for parents. Printing	A						X	X		OHD, ARH Center & Project HOPE, Oblast Educational Department, Health Institute branch	30000 booklets will be printed
Dissemination	A							X	X	OHD, ARH Center & Project HOPE, Oblast Educational Department, Health Institute branch	30000 will be disseminated to parents
Community mobilization activities on RH/ARH	BC							X	X	OHD, ARH Center & Project HOPE, Oblast Educational Department, Health Institute branch	Will be conducted various activities in community: meeting/discussion with woman RH age, adolescents; competitions, TV & Radio broadcast…
Capacity-Building											
Steering Committees	Q	X	X	X	X	X	X	X	X	Oblast administration, OHD & Project HOPE	8 Steering Committee meeting will be conducted
Working groups meetings	Q	X	X	X	X	X	X	X	X	OHD & Project HOPE	16 working group meeting will be conducted
Baseline survey			X							OHD & Project HOPE	1
MTE	Q								X	OHD & Project HOPE	1 will be conducted in the end of second year
KPC training	X on February								X		Will be trained 62 interviewers for Baseline survey and MTE
6 days LQAS training	Q				X					OHD & Project HOPE	20 (1 course) Local HP will be trained on LQAS
LQAS	Q				X		X		X	OHD & Project HOPE	Each 6 month
Create training room in each new rayons and Navoi rayon	A				X					OHD & Project HOPE	3 rooms
Create room for woman support group in new rayon Maternity houses and Navoi rayon maternity house	A				X					OHD & Project HOPE	3 rooms